UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

IN RE: NATIONAL HOCKEY LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	)	MDL No. 14-2551 (SRN/JSM)
This Document Relates to: ALL ACTIONS	)	

DEFENDANT'S OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND FOR APPOINTMENT OF CLASS REPRESENTATIVES AND CLASS COUNSEL

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Plaintiffs' motion asks the Court to embrace an unprecedented, deeply flawed choice-of-law methodology that would allow them to pick and choose elements of New York law and elements of Minnesota law, create a hybrid state's law that does not exist and apply it to an international class. They also seek to brush aside, with virtually no discussion, ***three*** binding Eighth Circuit opinions that have rejected similar medical-monitoring and issues class proposals. These legal barriers alone preclude certification.

But even if plaintiffs' class proposal were not barred by controlling Eighth Circuit caselaw, it would still fail because their own expert, Dr. Robert Cantu, has rejected the fundamental premise of plaintiffs' class proposal: that ***all*** former NHL players are at risk for a variety of neurodegenerative diseases, disorders or conditions ("NDDCs") identified by plaintiffs, creating common issues that can be adjudicated on a classwide basis. Contrary to plaintiffs' allegations, Cantu has conceded that: (1) assessing whether a given NHL player is at an increased risk of an NDDC would depend on that player's personal exposure (and, in any event, would require research that has yet to begin); (2) plaintiffs' theory of white matter loss – the initial mechanism by which they posit that head trauma might increase the risk of long-term disease – was "speculative" as of 2012 and remains an unpublished hypothesis; (3) while science has evolved significantly in recent decades, even Cantu would not "routinely warn" athletes in contact sports that they face an increased risk of NDDCs; and (4) he does not recommend "monitoring" for NHL

players in his own practice. (*See, e.g.*, Dep. of Robert Cantu ("Cantu Dep.") 121:12-122:11, 125:3-13, 465:16-466:19, 540:20-541:21, 545:1-14 (Ex. 1).)[1]

As set forth below, these legal and factual challenges preclude class treatment for a host of reasons.

First, plaintiffs fail to satisfy the cohesiveness and predominance requirements of Rules 23(b)(2) and 23(b)(3) because well-settled choice-of-law principles dictate the application of the laws of different states and provinces to the putative class members' claims. Plaintiffs seek to circumvent this precedent, including the Eighth Circuit's *St. Jude* ruling, by arguing that New York law should govern the question of "liability," while Minnesota law should govern the "remedial" question of whether to award medical-monitoring relief. But this proposal is profoundly wrong – from its failure to grasp that "liability" embraces not only duty and breach but also causation and injury, to its mistaken and unsupported assertion that a request for medical monitoring is a purely procedural matter of remedy. Under the only approach that has been followed by Minnesota courts and the Eighth Circuit, the governing laws will vary from player to player, making class treatment impossible.

Second, as in *St. Jude*, each proposed class member's claims will turn on highly individualized evidence related to, *inter alia*: his total exposure to head impacts

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[1] All numbered exhibits are attached to the Declaration of Daniel Connolly supporting this memorandum, and all lettered exhibits are attached to the Declaration of John Beisner, ECF 732.

(including concussions) while playing in the NHL and whether that level of exposure meets the potential threshold necessary to allegedly increase the risk of an NDDC; his exposure to head impacts outside the NHL (in youth, college and other leagues); what was known (or knowable) by the NHL during his career; what warnings and education the NHL provided while he was in the League; and what the player knew about the risks of head hits at that time.

Third, plaintiffs' proposed personal injury "issues" class is improper because the Eighth Circuit has rejected the use of issues classes to "manufacture" predominance that is otherwise lacking with respect to the class as whole. And as that court recently explained in *Ebert v. General Mills, Inc.*, 823 F.3d 472 (8th Cir. 2016), issues classes are especially inappropriate where, as here, causation and injury would remain to be decided in later proceedings, negating any efficiency benefits of class treatment. In any event, even the purportedly "common" issues plaintiffs identify (e.g., whether the NHL failed to warn players of an increased risk of disease) would turn on individualized evidence. This is all the more true because of the wide variety of neurological conditions plaintiffs have lumped together in this litigation.

Finally, a class action is not a superior mode of proceeding because the class vehicle was not intended as a means to conscript courts to usurp the role of the medical community or push the boundaries of scientific research. And class treatment is unnecessary in this context because the purported value of the relief plaintiffs seek is more than sufficient to justify individual suits by plaintiffs who feel aggrieved.

Plaintiffs' proposal is all the more improper because it is based on a false premise: that there is an epidemic of retired NHL players with neurodegenerative diseases. Aside from Larry Zeidel, [redacted]

For all of these reasons, plaintiffs' motion for class certification should be denied.

BACKGROUND

A. Procedural Background

Plaintiffs, former NHL players, allege that they are at risk of sustaining – or have sustained – various NDDCs as a result of playing NHL hockey. (Second Am. Class Action Compl. ("SAC") ¶1.) According to plaintiffs, the NHL knew or should have known that "persons who sustain repetitive concussive events, subconcussive events, or other brain injuries are at significantly greater risk for chronic neurodegenerative illness and disabilities both during their hockey careers and, especially, later in life," but failed to warn NHL players about these alleged risks. (*Id.* ¶¶5-6.)

Plaintiffs seek to certify two separate classes. "Class 1," the proposed medical-monitoring class, includes "[a]ll living Retired NHL Hockey Players" (Mem. 29), and "Class 2," the proposed issues class, includes "[a]ll Retired NHL Hockey Players (or

representative claimants if they are deceased) who have been clinically diagnosed with an NDDC" (*id.*). Class 2 plaintiffs seek certification as to "particular issues" relevant to their negligence and negligent misrepresentation claims, including: "[w]hether the NHL owed duties of care under negligence standards"; "[w]hether the NHL breached those duties, including by failing to warn"; "[w]hether head impacts experienced in NHL-style play substantially contribute to the development of signature [NDDCs] as described in the Complaint"; and "[w]hether retired players are at an increased risk of developing" these conditions. (Jan. 19, 2017 Ltr. from C. Zimmerman to Hon. S. Nelson ("Zimmerman Letter") at 4, ECF 665.)

There are six named plaintiffs in this case. Five are retired, living NHL players: David Christian, Daniel LaCouture, Reed Larson, Gary Leeman and Bernie Nicholls. The sixth is the Estate of Larry Zeidel, a longtime minor league hockey player who played in the NHL for a small portion of his career and died in 2014, at age 87. Plaintiffs Christian and Larson seek to represent Class 1 ***if*** the Court accepts their proposal to apply an amalgam of New York and Minnesota law to the entire class. (Mem. 41, 64, 69.) In the alternative, plaintiffs propose Nicholls and LaCouture as additional representatives of Class 1. Leeman and the Zeidel Estate seek to represent Class 2. (*Id.* 30.)

B. The Science Regarding The Hypothesis That Retired Athletes Develop CTE Has Evolved Over Time.

The scientific community's understanding of CTE is still in its "infancy."[2] As Cantu conceded at his deposition, "'a cause-and-effect relationship has not as yet been demonstrated between CTE and concussions or exposure to contact sports.'" (Cantu Dep. 335:8-16 (citation omitted).) Rather, existing evidence of CTE is "'limited to case reports in series,'" and "'does not permit identification of incidence rates or risk factors.'" (*Id.* 378:18-379:3 (citation omitted); *see also* Decl. of Paul McCrory ("McCrory") ¶96 (Ex. K) ("There is much more to learn about the potential cause and effect relationships of repetitive head impact exposure, concussions, and long-term brain health. … More research on the long-term sequelae is needed to better understand the incidence and prevalence of CTE or other neurodegenerative conditions among former athletes.").[3]

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[2] Stern, R. et al., *Long-term Consequences of Repetitive Brain Trauma: Chronic Traumatic Encephalopathy*, PM&R (2011) (Ex. 4) ("Although we know much more about certain aspects of the disease now compared with just 5 years ago, especially the neuropathology and clinical history associated with CTE, we remain in infancy in the study of CTE.").

[3] The recently released 2016 Consensus Statement, by the Concussion in Sports Group ("CISG"), a panel of prominent concussion experts, is in accord. *See* McCrory, P. et al., *Consensus Statement on Concussion in Sport: The 5th International Conference on Concussion in Sport Held in Berlin*, October 2016, Br J Sports Med (2017) (Ex. 5) ("A cause-and-effect relationship has not yet been demonstrated between CTE and [sport-related concussions] or exposure to contact sports. As such, the notion that repeated concussion or subconcussive impacts cause CTE remains unknown.").

Plaintiffs nonetheless contend that "there has been a clear association … between repeated blows to the head in sports" and CTE "[s]ince 1928[.]" (Decl. of Stephen Casper ("Casper") ¶19, ECF 644; *see also* Decl. of Robert Cantu ("Cantu") ¶95, ECF 646; Decl. of Dawn Comstock ("Comstock") ¶119, ECF 642; SAC ¶¶178-79.) To support this assertion, plaintiffs rely heavily on a smattering of case studies dating from 1928 to the present. They first point to a 1928 article in the *Journal of the American Medical Association* ("JAMA") that described a "peculiar condition" affecting long-term boxers. This syndrome was referred to as being "punch drunk," with hallmark features including gait disturbance, dysarthria, tremor and cognitive impairment.[4] Between the 1930s and the 1960s, a number of case studies of boxers were published describing this syndrome.[5] Like Martland's work, these case reports described non-specific, clinical symptoms and did not purport to link them to any particular pathology. (Decl. of Grant Iverson ("Iverson") ¶¶73-77 (Ex. I); Decl. of Rudy Castellani ("Castellani") ¶¶77-78 (Ex. C).) The sporadic attention to this syndrome in boxers emerged again in a 1973 case series led by Corsellis.[6] This case series included the brains of 15 boxers and proposed

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[4] Martland, H., *Punch Drunk*, JAMA (1928) (Ex. 6) (cited in Comstock ¶119; Cantu ¶¶29, 95; Casper ¶¶81, 217).

[5] *See, e.g.*, Mawdsley, C., Ferguson, R., *Neurological Disease in Boxers*, Lancet (1963) (Ex. 7); Denst, J. et al., *Chronic Encephalopathy Following Minor Head Injury*, AMA Arch Pathol (1959) (Ex. 8); Payne, E.E., *Brains of Boxers*, Neurochirurgia (1968) (Ex. 9).

[6] *See* Corsellis, J.A. et al., *The Aftermath of Boxing*, Psychol Med (1973) (Ex. 10) (cited in Cantu ¶95; Casper ¶202).

gross and microscopic neuropathology criteria for CTE (but did not establish any diagnostic criteria). (Castellani ¶¶79-82; Iverson ¶78.)

The very articles relied on by plaintiffs' experts make clear that these various findings in boxers did not apply to other sports. *See, e.g.,* Adams, I.D., Potter, J., *Brain Damage in Sport,* Lancet (1976) (Ex. 11) (asking rhetorically whether "any sport other than boxing involve[s] repeated blows to the head which are intense enough to produce an irreversible 'traumatic encephalopathy' in any way resembling the punch-drunk state" and responding that "[t]he shorter answer, on both clinical and pathological grounds, is No"); Critchley, M., *Medical Aspects of Boxing, Particularly from a Neurological Standpoint,* Br Med J (1957) (Ex. 12) ("One important distinction … distinguishes boxing from most other forms of athleticism. Injuries are coincidental in other sports, but in boxing the aim and object … is to render the opponent *hors de combat*."). (*See also* Decl. of Lisa Brenner ("Brenner") ¶50 (Ex. A) (because the blows sustained by boxers in the Martland study were "'severe'" and, in some cases, resulted in a loss of "'consciousness … for a considerable period of time[,]'" its "[i]mplications for milder and less frequent trauma that might be associated with contact sports are not evident").)

Following 1973, the scientific research related to CTE did not advance substantively for several decades. In 2004, the World Health Organization published the

results of a six-year systematic review evaluating studies from 1980-2000 about post-mTBI prognoses, and the authors did not even address CTE.[7]

The following year, in 2005, Dr. Bennet Omalu published an article describing the autopsy results of a former NFL player whose brain he considered normal except for the accumulation of tau.[8] Omalu identified this as a new condition, distinct from what had been observed in boxers, with ***different*** pathological and clinical criteria. He called this new condition "chronic traumatic encephalopathy," or CTE, because it had been used as "a descriptive terminology in the literature" (though not as the name of a disease).[9] Omalu "believed [he] had discovered a new disease in an American football player, a disease that had to be named."[10]

Omalu's 2005 findings marked the starting point for nearly all research into the potential long-term effects of head impacts in sports other than boxing. Dr. Ann McKee, one of the researchers at the Boston University CTE Center (with which Cantu is affiliated), recently explained that Omalu's 2005 article was a "surprise" and "revelation"

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[7] Carroll, L. et al., *Prognosis for Mild Traumatic Brain Injury: Results of the WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury*, J Rehabil Med (2004) (Ex. 13). (*See also* Decl. of David Cassidy ("Cassidy") ¶61 (Ex. B).)

[8] *See* Omalu, B. et al., *Chronic Traumatic Encephalopathy in a National Football League Player*, Neurosurgery (2005) (Ex. 14).

[9] Omalu's work had many limitations, which are addressed in the declaration of Dr. Castellani, Director of the Western Michigan Center for Neuropathology. (Castellani ¶113.)

[10] Omalu, B., *Concussions and NFL: How the Name CTE Came About*, www.cnn.com/2015/12/21/opinions/omalu-discovery-of-cte-football-concussions.

that "shocked" her and "was the start of" scientists' research in this area.[11] Omalu was similarly "flabbergasted" by his apparent discovery and "believed [he] had found something distinctive."[12]

In 2009, McKee and her colleagues conducted a literature review that identified 48 known cases of CTE in boxers and added three new case reports, including one of an NFL player.[13] This paper purportedly documented the clinical and neuropathological characteristics of CTE, but used different pathological criteria from those described by Omalu or in previous case reports of CTE in boxers. Four years later, in 2013, based on her observations of varying degrees of tau pathology in different brains, McKee identified what she described as the four neuropathological "stages" of CTE.[14] The "stages" identified by McKee differ from the four neuropathological "phenotypes" of CTE identified by Omalu and colleagues in a 2011 paper.[15]

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[11] Transcription of Ann McKee Facebook Live Q&A, Feb. 1, 2017 ("McKee Facebook Tr.") 5:12, 5:21, 6:2-3 (Ex. 15).

[12] Omalu, B., *supra* n.9.

[13] McKee, A.C. et al., *Chronic Traumatic Encephalopathy in Athletes: Progressive Tauopathy After Repetitive Head Injury*, J of Neuropath & Experimental Neurol (2009) (Ex. 16).

[14] McKee, A.C. et al., *The Spectrum of Disease in Chronic Traumatic Encephalopathy*, Brain (2013) (Ex. 17).

[15] Omalu, B. et al., *Emerging Histomorphologic Phenotypes of Chronic Traumatic Encephalopathy in American Athletes*, Neurosurgery (2011) (Ex. 18). Neither of these approaches was ultimately adopted by the Consensus Conference convened by the National Institutes of Health ("NIH") in 2015 to define the neuropathological criteria for CTE diagnosis. (Castellani ¶¶69-70.)

Other recent research has attempted to understand possible mechanisms by which head trauma might cause permanent pathological changes in the brain. In a 2012 study highlighted by Cantu, for example, researchers claimed to find white matter changes in one amateur hockey team over the course of a single season – findings that Cantu described as "new and novel and very provocative" at the time they were made. (Cantu Dep. 125:3-18.) The study did not examine whether any permanent changes to white matter occurred and did not link the purported changes in white matter to any present or future clinical symptoms. Moreover, because the study had a "very small sample size with no control," Cantu conceded that it would "not [be] inappropriate" to call its findings "speculative." (*Id.* 125:9-13; *see also* Decl. of Christopher Randolph ("Randolph") ¶25(d)(ii) (Ex. R) (explaining why it is currently "impossible to draw any valid scientific conclusions from this area of research").)

Even today, the work of understanding CTE and its posited relationship to head trauma remains nascent. As explained by neurologist Dr. Kristine Yaffe, the director of the University of California San Francisco's Dementia Epidemiology Research Group, there is currently no "consensus as to what CTE is, and there certainly is no study showing that concussion or anything else causes CTE." (Decl. of Kristine Yaffe ("Yaffe") ¶71 (Ex. U).)[16] "Without such consensus or understanding of causation in the

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[16] (*See also* Cassidy ¶19 ("The current state of the science and the available epidemiological evidence do not support the conclusion of a causal relationship between concussions or subconcussive blows and" CTE or other NDDCs).) Indeed, there is insufficient evidence to establish whether CTE is a static, progressive or even regressive *(cont'd)*

scientific community, it is impossible to determine whether or to what extent the variety of symptoms claimed by an individual are related to the onset of CTE, or even whether any suspected case of CTE is attributable to head hits sustained by the individual." (*Id.*)[17] Such a relationship (if it exists) cannot be shown until prospective, longitudinal studies evaluate exposed and unexposed populations to establish incidence or prevalence rates in the general population and/or by sport. (Cassidy ¶31; Castellani ¶¶21, 102; Hazrati ¶¶40, 52.)

Expert panels and government bodies have reached similar conclusions. After considering the limited case reports, the 2012 CISG Consensus Statement (signed by Cantu) concluded "that a cause and effect relationship has not yet been demonstrated between CTE and concussions or exposure to contact sports" and that CTE "represents a distinct tauopathy with an unknown incidence in athletic populations."[18]

In 2014, the International Collaboration on Mild Traumatic Brain Injury Prognosis ("ICoMP") updated the 2004 WHO findings, noting that "there are no established clinical criteria for CTE," and highlighting that uncertainties remain regarding the relationship

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condition. (Iverson ¶¶87-88; Castellani ¶¶26, 104, 109, 117, 119; Decl. of Lili-Naz Hazrati ("Hazrati") ¶¶33, 48 (Ex. H).)

[17] (*See also* Decl. of Julie Schneider ¶¶37-38 (Ex. T) (causality of and risk factors for CTE not yet established).)

[18] McCrory, P. et al., *Consensus Statement on Concussion in Sport: the 4th International Conference on Concussion in Sport Held in Zurich, November 2012*, Br J Sports Med. (2012) (Ex. 19).

between ***mTBI*** and CTE.[19] That same year, the National Athletic Trainers' Association stated that "the relationship among concussion, subconcussive impacts, and long-term brain health ***is not clear***."[20] The panel, which also included Cantu, characterized existing research as "preliminary," explaining that research that could "directly associate concussive and subconcussive impacts with cognitive health, while controlling for normal age-related declines and other factors, has not been completed."[21]

In 2015, the NIH convened a Consensus Conference to define the neuropathological criteria for CTE diagnosis, which were characterized as an "accumulation of abnormal p-tau in neurons, astrocytes, and cell processes around small vessels in an irregular pattern at the depths of the cortical sulci."[22] (Castellani ¶69.) This pattern of p-tau "was believed to differ from aging and other diseases." (*Id*.) As Cantu conceded, the NIH's statement "obsolete[d] a tremendous amount of" prior CTE

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19 Godbolt, A. et al., *Systematic Review of the Risk of Dementia and Chronic Cognitive Impairment After Mild Traumatic Brain Injury: Results of the International Collaboration on Mild Traumatic Brain Injury Prognosis*, Archives of Physical Medicine and Rehabilitation (2014) (Ex. 20).

20 *National Athletic Trainers' Association Position Statement—Management of Sport Concussion*, J. of Athletic Training (2014), https://www.nata.org/sites/default/files/Concussion_Management_Position_Statement.pdf (emphasis added).)

21 *Id.*

22 Tau is a protein that is relatively abundant in neurons but also is present in all nucleated cells. Tau can become misfolded and/or abnormally phosphorylated, a condition which is referred to as a "tauopathy," and encompasses the broad classification of neurodegenerative diseases such as Alzheimer's disease, CTE, Down's syndrome, progressive supranuclear palsy, corticobasal degeneration, frontotemporal dementias, and Parkinsonism. (Castellani ¶¶133-34.)

literature, which used different pathological criteria. (Cantu Dep. 169:14-21, 171:4-172:12.)

Pathological research underscores that much further refinement beyond identification of tau remains to be accomplished before a reliable pathological profile of CTE is developed. For example, research has found that some athletes have p-tau deposits consistent with CTE, other athletes with similar exposure have no remarkable pathological findings, and people with no history of playing contact sports have p-tau deposits consistent with CTE. (Hazrati ¶¶30, 32; Castellani ¶25.) Cantu conceded that the physiological process by which head trauma ostensibly leads to CTE pathology remains an "unproven theory." (Cantu Dep. 205:19-206:3.) In addition, "there are no agreed upon or validated clinical criteria for diagnosing CTE in a living person." (Iverson ¶21.)

Cantu confirmed that any causal relationship between head injury in contact sports and later-in-life development of CTE remains scientifically unproven; that it "remains to be shown" that any association between participation in contact sports and development of CTE is a "cause-and-effect" relationship; and that prospective studies using "rigid scientific criteria" and examining dose-response relationships on a sport-by-sport basis are needed to "show causality." (Cantu Dep. 381:12-386:2; *see also id.* 58:22-61:5, 250:8-252:7, 268:19-269:9.) Cantu also testified that with respect to hockey specifically, scientists have not examined "enough brains to ***try to start to equate exposure with CTE***." (*Id.* 459:13-21 (emphasis added).) And the task of establishing a threshold for any increased risk of CTE in NHL players is even further off; as Cantu put it, "[w]e're

not in the ballpark of being able to talk about incidence or prevalence" in the general population, and "we don't know the incidence or prevalence within NHL hockey." (*Id.* 451:6-11; Iverson ¶23 ("there are no published studies showing that former amateur or professional hockey players have increased rates of either the neuropathology or the clinical features of CTE"); Cassidy ¶21 ("There are currently no studies of the risk of CTE in any comparative population, nor are there studies that measure the relative or absolute risk of CTE in athletes, including hockey players.").)

Despite this uncertainty, scientists generally agree that a single concussion is ***unlikely*** to cause CTE, and Cantu maintains that even multiple well-managed concussions are not dangerous in the long term. (*See* Cantu Dep. 97:8-21 ("As far as we know, a concussion is not sufficient to result in chronic traumatic encephalopathy."); *id.* 415:11-418:21 (recalling treatment of one NHL player who sustained four concussions but was nevertheless cleared by Cantu to continue playing); Boston_Bruins0028849 (Ex. 21) (Cantu writing that "numerous professional athletes in my experience have continued careers safely and successfully after suffering as many as ten or more concussions").) McKee similarly stated earlier this year that "you shouldn't worry about CTE after one concussion, or even a few that have been well managed." (McKee Facebook Tr. 8:6-9:2.) Instead, as Cantu explained, the threshold of total hits beyond which a player might be at risk of CTE is likely to be very individualized, and an athlete's sport, position and concussion history would need to be considered when analyzing his risk of CTE. (Cantu Dep. 239:19-241:1.)

C. The Relationship Between mTBI And Other NDDCs Is Scientifically Unsupported.

Although plaintiffs focus on CTE, they also seek recovery for a range of other neurological conditions, including amyotrophic laterals sclerosis ("ALS"), Alzheimer's disease, Frontotemporal Dementia, Lewy Body Dementia, Parkinson's disease and other "cognitive, mood, or behavioral conditions." (*See* SAC ¶399.)

While the scientific research related to these diseases has similarly progressed over distinct timelines, there is no consensus in the medical literature that mTBI increases the risk of ***any*** of the NDDCs specified by plaintiffs, and research concerning any relationship between mTBI and some of these diseases is nonexistent. (Yaffe ¶¶14, 42-61.) The WHO's 2004 systematic review stated that "findings regarding the role of mTBI as a risk factor for dementia should be considered inconclusive,"[23] a conclusion ICoMP echoed in 2014, stating that "there is insufficient evidence to draw any conclusion about a potential risk of dementia after mTBI (either single or repetitive injury). Clinicians and policymakers should be cautious about attempting to address this issue until more evidence is available."[24] Moreover, there are no "published studies showing that former amateur or professional hockey players have increased rates of" NDDCs. (Iverson ¶23.) As with CTE, future, prospective studies that examine dose-response relationships between head impacts and long-term outcomes, on a sport-by-

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23 Carroll et. al., *supra* n.6.

24 Godbolt et al., *supra* n.19.

sport basis, are needed before any causal relationship could be shown between participation in sport and these NDDCs. (Cantu Dep. 250:8-252:7, 381:12-383:4.)

As Dr. Yaffe explains, each of the diseases plaintiffs identify has numerous risk factors, including age, education level, family history of neurodegenerative disease, cardiovascular disease, stroke, diabetes, high blood pressure, obesity, substance abuse, depression and sleep conditions. (Yaffe ¶39.) The risk factors associated with "cognitive, mood, or behavioral conditions" (*see* SAC ¶399) are even more confounding, as explained by Dr. Jennifer Finkel, Assistant Professor in the Departments of Psychiatry and Neurology at the Mount Sinai School of Medicine. For example, sleeping problems are "caused by a number of different conditions, including depression, bipolar disorder, anxiety, … drug use, certain medications and various thyroid conditions." (Suppl. Decl. of Jennifer Finkel ("Finkel Suppl.") ¶17 (Ex. D).) Poor concentration has "multifactorial causes, including depression, attention deficit hyperactivity disorder, anxiety, alcohol use, cocaine and other drug use, insomnia or fatigue, acute stress reactions, hypoglycemia and neurological issues (stroke, infection, tumor)." (*Id.*) And depression is associated with a number of conditions and has its own risk factors, including alcoholism, drug abuse, traumatic or stressful life events, negligent/traumatic childhood, financial and psychological stressors. (*Id.*; *see also* McCrory ¶97 ("The causes of mental health and cognitive problems in former athletes, like the general population, are broad and diverse, and include genetics, life stress, general medical problems (e.g., hypertension, diabetes, and heart disease), chronic bodily pain, substance abuse, neurological conditions and

disease (e.g., cerebrovascular disease), and neurodegenerative diseases (e.g., Alzheimer's disease, Parkinson's disease, and ALS)."); Iverson ¶¶134-43.)

Finkel, who performed a comprehensive psychiatric evaluation and medical record review of four of the named plaintiffs, concluded [redacted]

D. Scientific Understanding Of Subconcussive Hits Is Even Less Developed.

There "is no consensus in the medical or scientific community about the definition of 'subconcussive' blows, impacts, or injuries." (Iverson ¶151.) Subconcussive hits have

only been "mentioned hypothetically in some literature" until very recently, and there generally has been "very little systematic study" of such head hits. (Yaffe ¶22; *see also* Brenner Table 1 ("'Human studies of the neurological/neuropsychological impact of subconcussive blows are currently quite limited.'"); Decl. of Douglas McKeag ¶23 (Ex. L) ("[S]ubconcussion" is an "emerging concept ... '[o]ur understanding of [which] is still in its infancy and evolving.'").) According to Cantu, "it has truly been [in] the last few years that most of the studies of subconcussive blows have been published." (Cantu Dep. 279:16-19.) Moreover, the few studies that have addressed subconcussive hits have been inconclusive and do not support a finding that subconcussive hits have significant clinical effects in humans. (*See* Decl. of Kevin Guskiewicz ¶66 (Ex. G) (noting that there are no published studies "that can answer the question about the association between subconcussive impacts and LTNDs"); Cassidy ¶23 (stating that subconcussive blows have "not been the subject of rigorous scientific studies").)

Professor Hoshizaki relies on animal studies in which cell cultures from guinea pigs, squids and rats were stretched in laboratories to opine that a subconcussive hit that creates between 8 and 15% maximum principal strain can cause white matter damage and increases to tau and serum neurofilament light polypeptide. (Dep. of Thomas Hoshizaki ("Hoshizaki Dep.") 365:14-367:20 (Ex. 22); Decl. of Thomas Hoshizaki ("Hoshizaki") ¶¶11-12, 33, ECF 645.) But, as explained in the NHL's motion to exclude his opinions, Hoshizaki misconstrues the findings of these studies and makes several analytical leaps to reach his conclusions. There is no peer-reviewed published literature supporting the notion that subconcussive hits cause white matter damage, let alone that such damage

leads to the development of NDDCs. (Mot. to Exclude Ops. of Prof. Hoshizaki at 40-41 (filed separately).)[25]

E. The NHL And NHLPA Have Changed Their Approaches To Concussions As The Science Has Evolved.

While the NHL and NHL Players' Association ("NHLPA") have always had a strong commitment to player safety within the context of a physical, contact sport, their approaches to improving player safety with respect to head injuries have changed over time as information regarding the potential risks of head hits has evolved.

Injury Tracking Efforts And The Development Of A Concussion Program. Since the late 1970s, the NHL has collected data regarding player injuries. (*See* Decl. of William Daly ("Daly") ¶108, ECF 751.) In the late 1980s, the NHL supported the development of a Team Physician's Society – a group of team physicians who meet regularly to discuss the League's medical issues. (*Id.*)

In 1997, the NHL and NHLPA jointly established a "Concussion Program" to study the physiology and incidence of concussions and determine whether neuropsychological testing could aid in their management. The primary function of the Concussion Program has been to adopt protocols to improve the acute evaluation, diagnosis and management of concussions in the NHL, and the Concussion Program

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[25] The absurdity of Hoshizaki's opinions is evidenced by the fact that applying his methodology leads to the conclusion that every person who has ever jumped rope has suffered permanent brain injury. (*See* Decl. of Matthew Panzer ("Panzer") ¶23 (Ex. Q).)

continues to evolve to reflect current medical and scientific consensus and best practices. (*Id.* ¶¶110-21.)[26]

In January 2010, the NHL and NHLPA published their first comprehensive "Concussion Protocol," a document codifying existing practices and governing all phases of concussion evaluation and management in the NHL. (*Id.* ¶117.) That document has evolved over time, including the following changes (among others): (1) adoption of a requirement that concussion evaluation take place in what is referred to as the "quiet room" (i.e., a distraction-free environment); (2) updates to the tools and methods used to assist in concussion evaluation and management; (3) modifications to return-to-play guidelines; and (4) provision for designated team and League "spotters" who watch each NHL game and look for signs of possible concussion exhibited by players that might not be detected by other personnel. (*Id.* ¶¶117-24.)

Warnings And Education Regarding The Risks Of Concussions And Head Injuries. The NHLPA historically has taken primary responsibility for educating players regarding concussions and their potential risks. (*Id.* ¶126; Rizos Dep. 28:18-30:1, 73:2-18; NHLPA_0021513 (Ex. 26).)[27] The NHL has, however, worked with the NHLPA to

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[26] Plaintiffs assert that the NHL has "ke[pt] its concussion data to itself" (Mem. 16), but all data have been shared with the NHLPA – and ongoing research was presented to the CISG as well. (*E.g.*, Dep. of John Rizos ("Rizos Dep.") 121:14-123:9, 239:13-241:18, 339:10-340:3 (Ex. 23); Dep. of Ruben Echemendia 63:12-64:9, 94:16-96:10 (Ex. 24); Dep. of Willem Meeuwisse 371:9-18 (Ex. 25).)

[27] Plaintiffs' contrary assertion that the NHL "has always … exercised unilateral power over … player education" (Mem. 5) is wrong; [redacted]

(cont'd)

educate and warn players regarding the seriousness of head injuries and concussions, including the potential risks associated with concussions. As discussed below, these communications have evolved over time to account for changing science.

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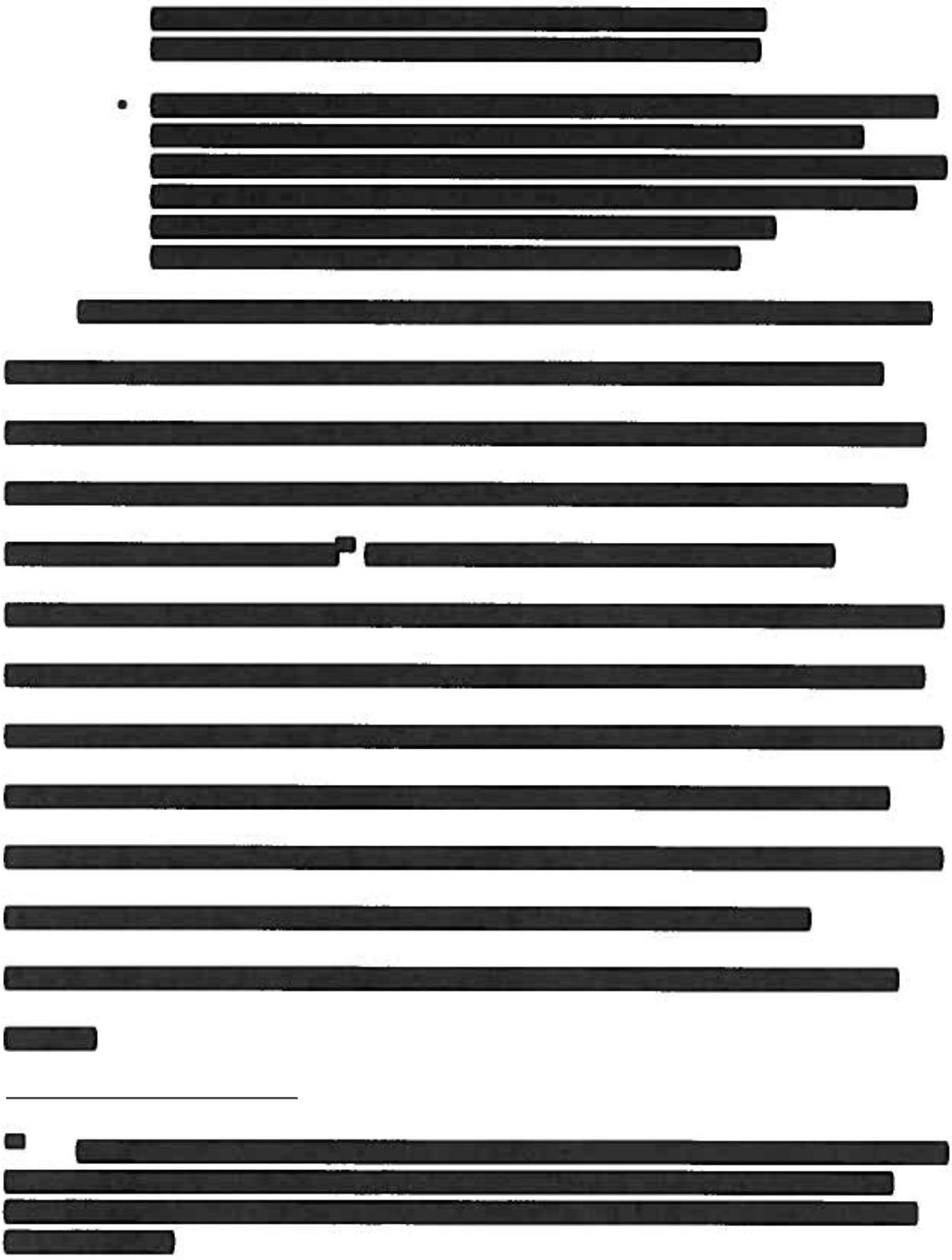

In addition, the NHL and NHLPA have jointly provided warnings and education to players regarding head injuries and concussions, which have similarly evolved over time. For example, in a joint 1997 letter to players explaining the newly instituted neuropsychological testing requirements, NHL and NHLPA medical consultants warned that "with repeated minor brain injury the risk that the temporary problems become permanent increases." (Daly ¶126; NHLPA_0013785 (Ex. 39); NHLPA_0021162 (Ex. 40).) In addition, in 2001, NHL/NHLPA-issued notices were posted in all NHL Club locker rooms and distributed to all players, warning that the "consequences of sustaining a direct blow to your head without head protection could not only be career ending (i.e. permanent brain injury) but also fatal (i.e. death)." (Daly ¶128; NHL1351631 (Ex. 41).) In 2002, the NHL and NHLPA created an educational video featuring Brett Lindros, a former NHL player who retired as a result of concussions; the video warned that "injuries to the head can end hockey careers and can adversely affect a player's life and lifestyle after hockey." (Daly ¶129; NHL2339228 (Ex. 42).) Lindros further advised players: "As most of you know my career was cut short due to post-concussion syndrome.... Head injuries are serious and need to be treated as such." (NHL2339228.) The video was required to be shown to all players during training camp before the 2002-03 season. (Daly ¶129.)

The NHL provided additional warnings and education to players in conjunction with the NHLPA over time. For example:

- In 2008, the NHL and NHLPA updated safety notices posted in locker rooms to warn players that continuing to play with concussions and failing to report concussion-related "symptoms may lead to extended time loss,

ending your career and permanent brain damage." (Daly ¶126; NHL0217631 (Ex. 43).)

- In 2009, the NHL and NHLPA, along with the National Academy of Neuropsychology, created a new video featuring Eric Lindros, warning that "a concussion you get now could have long-term lasting effects that can be with you the rest of your life." (Daly ¶130; NHL2339229 (Ex. 44).) Cantu participated in the creation of this video and testified that he "thought it was well done." (Cantu Dep. 444:9-445:9.) [redacted]

- Since 2009, NHL/NHLPA-issued notices have warned players that failure to report concussion-related symptoms may result in "permanent injury and even end your career." (Daly ¶126; NHL0218052 (Ex. 45).)

- Since 2013, the NHL/NHLPA Rookie Orientation Program has addressed concussions and their potential long-term effects, including by educating players about CTE. (Daly ¶132; NHL2080601 (Ex. 46); Kutcher Dep. 129:5-132:4, 324:22-326:19.)

- In 2015, the NHL/NHLPA Concussion Subcommittee produced another educational video stating: "Some researchers have suggested a relationship exists between head impacts in sport and CTE. Other researchers and international bodies state that a causal link between head impacts in sport and CTE has not been established. However, researchers agree that further study is needed to fully understand what relationship may exist between the two." (Daly ¶133.)

Rule Changes To Improve Player Safety. The NHL's power to adopt or modify League rules is significantly limited by the role of the NHLPA, which has existed since 1967, and the collective bargaining agreements ("CBAs") negotiated between the NHL

and NHLPA, which date back to 1975. (*See id.* ¶¶4-13.)[29] The NHL has worked with the NHLPA to improve player safety via rule changes over time. For example:

- Dating back to at least the 1996-97 season, the NHL has strictly applied supplemental discipline in situations where illegal contact is made with an opponent's head. (*Id.* ¶24; NHL0218806 (Ex. 47).)

- This supplemental discipline standard was amended in 1998, 2000 and 2007 to better address head hits. (Daly ¶¶25-28; NHL0117893 (Ex. 48); NHL2078259 (Ex. 49); NHL0217544 (Ex. 50).)

- In 2010, the NHL and NHLPA adopted Rule 48, an on-ice penalty prohibiting certain forms of targeted head hits. (Daly ¶¶56-58; NHL2189741 (Ex. 51).)

Similarly, with regard to fighting:

- The original penalty for fighting in the NHL was a two-minute minor penalty, and in 1947, the rule was amended to a five-minute major penalty. (Daly ¶66; NHL0136529-798 (Ex. 52).)

- In the 1960s, 1970s and 1980s, the fighting rules were changed to further penalize players who leave the bench to fight or interfere in an altercation already in progress between two other players. These rules were designed to keep one-on-one contests from turning into dangerous brawls between many players. (Daly ¶¶66-67; NHL0136529-798.)

- In the 1990s, the NHL and NHLPA amended rules to target players who instigate fights. (Daly ¶77; NHL0136529-798.)

More recently, the NHL proposed a rule intended to eliminate "staged fights" (i.e., fights initiated immediately following a face-off without any clear provocation), which the NHLPA opposed. (Daly ¶¶70-75; NHL0581021-22 (Ex. 53).) Subsequently, the

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[29] Even prior to the NHLPA's founding, NHL owners and players had formed an "Owner-Player Council" to meet and discuss issues including playing rules and player safety. (Daly ¶13.)

NHL proposed – and the NHLPA agreed to – rules requiring players to wear visors and to keep helmets on during fights. (Daly ¶86.) Notably, fighting has declined significantly in recent years. (*Id.* ¶64.)

ARGUMENT

A class action is "an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 348-49 (2011) (citation omitted). To come within the exception, "a party seeking class certification must affirmatively demonstrate his compliance" with Rule 23. *Id*. at 350. Specifically, a court considering class certification must perform a "'rigorous analysis'" of the Rule 23 requirements "that includes [an] examination of what the parties would be required to prove at trial" to establish the required elements of their claims and whether such proof can be made with respect to the class as a whole based on common evidence. *Avritt v. Reliastar Life Ins. Co*., 615 F.3d 1023, 1029 (8th Cir. 2010); *Elizabeth M. v. Montenez*, 458 F.3d 779, 786 (8th Cir. 2006) (similar). Resolution of the class certification question will often "require the court to resolve disputes going to the factual setting of the case, and such disputes may overlap the merits of the case." *Blades v. Monsanto Co*., 400 F.3d 562, 567 (8th Cir. 2005). As set forth below, plaintiffs' class certification proposal cannot survive a rigorous analysis.

I. PLAINTIFFS MISTAKENLY INVOKE RULE 23(B)(2), BUT APPLICATION OF EITHER RULE 23(B)(2) OR RULE 23(B)(3) LEADS TO THE SAME RESULT.

A. The Court Should Evaluate Plaintiffs' Proposal Under Rule 23(b)(3).

As a threshold matter, plaintiffs' class proposal should be evaluated under Rule 23(b)(3) – not Rule 23(b)(2).

Rule 23(b)(2) "was 'designed specifically for civil rights cases seeking broad declaratory or injunctive relief for a numerous and often unascertainable or amorphous class of persons.'" *Barnes v. Am. Tobacco Co.*, 161 F.3d 127, 142 (3d Cir. 1998) (citation omitted). Accordingly, it does not apply where the alleged injuries are particular to the claimant and/or the predominant relief requested is monetary. *See In re St. Jude Med., Inc.*, 425 F.3d 1116, 1121 (8th Cir. 2005). Because a demand for medical monitoring is ultimately a request that defendants be ordered to pay money to individuals for their personal exposures, proposed medical-monitoring classes generally fall outside the ambit of Rule 23(b)(2). *See, e.g., Zinser v. Accufix Res. Inst., Inc.*, 253 F.3d 1180, 1195, *amended by* 273 F.3d 1266 (9th Cir. 2001); *Boughton v. Cotter Corp.*, 65 F.3d 823, 827 (10th Cir. 1995) (affirming rejection of medical-monitoring class under Rule 23(b)(2) because "the relief sought was primarily money damages"); *Duncan v. Nw. Airlines, Inc.*, 203 F.R.D. 601, 611 (W.D. Wash. 2001) (similar; "[a]lthough the plaintiff now characterizes the relief as a program rather than a fund, the bottom line is money"). This is true even where medical-monitoring plaintiffs also seek an order compelling research or studies because such "injunctive relief is merely incidental to the primary

claim for money damages." *Zinser*, 253 F.3d at 1196; *Lewallen v. Medtronic USA, Inc.*, No. C 01-20395 RMW, 2002 WL 31300899, at *3 (N.D. Cal. Aug. 28, 2002) (similar).

Here, plaintiffs' so-called medical-monitoring "program" is effectively a compensatory monetary award to finance future medical screening expenses. As Cantu explains, plaintiffs are requesting that the NHL pay approximately $10,250 per former player to cover the costs of an initial medical examination, plus an additional $3,500 per player every five years for subsequent neuropsychological screenings. (Cantu ¶¶136-44.) The approximate cost of conducting just the initial exams of all 5,100 putative class members would be over $52 million. This is the very definition of a request for monetary relief.

Plaintiffs' cases are not to the contrary. For example, *DeBoer v. Mellon Mortgage Co.*, 64 F.3d 1171 (8th Cir. 1995) (Mem. 57), involved a request to enjoin a financial-services company from charging certain escrow fees. *In re St. Jude Medical, Inc. Silzone Heart Valves Products Liability Litigation*, No. MDL 01-1396 JRTFLN, 2004 WL 45504 (D. Minn. Jan. 5, 2004) (Mem. 57), was ultimately reversed by the Eighth Circuit. *See St. Jude*, 425 F.3d at 1122. And *Donovan v. Philip Morris USA, Inc.*, 268 F.R.D. 1, 22 (D. Mass. 2010), involved a proposal for "a structured program, monitored by and staffed with medical personnel," who would perform testing using technology that was not generally available to medical providers. Here, by contrast, plaintiffs ask the NHL to pay for generally available tests to be conducted by neuropsychologists, neurologists, radiologists and psychiatrists at some unidentified constellation of "regional hospitals or centers across the United States and Canada." (Cantu ¶142.) In other words, unlike in

Donovan, the testing plaintiffs seek is commonly available – and no program is required to administer it. (*See* Suppl. Decl. of C. Warren Olanow ("Olanow Suppl.") ¶99 (Ex. O).)

For all of these reasons, plaintiffs' class proposal is more properly assessed under Rule 23(b)(3).[30]

B. Plaintiffs' Class Proposal Is A Non-Starter Under Either Subsection.

Regardless of whether the Court applies Rule 23(b)(2) or (b)(3), plaintiffs' class proposal fails because their claims are so legally and factually individualized that they cannot be resolved together based on common evidence.

"Although Rule 23(b)(2) does not refer to the predominance of common questions, 'class claims thereunder must still be cohesive.'" *Avritt*, 615 F.3d at 1035 (quoting *St. Jude*, 425 F.3d at 1121). Indeed, "[b]ecause a (b)(2) class is mandatory" – meaning that class members ***do not*** have the ability to opt out – "the cohesiveness requirement of Rule 23(b)(2) is ***more*** stringent than the predominance and superiority requirements" of Rule 23(b)(3). *Ebert*, 823 F.3d at 480 (emphasis added); *see also Foster v. St. Jude Med., Inc.*, 229 F.R.D. 599, 607 (D. Minn. 2005) ("[T]he issues that defeat the predominance and superiority requirements of Rule 23(b)(3) also preclude certification under [the cohesiveness requirement of] Rule 23(b)(2)."); *Gates v. Rohm & Haas Co.*, 655 F.3d 255,

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[30] Application of Rule 23(b)(2) would also raise due-process concerns regarding absent class members' rights. Where, as here, the proposed members allege different degrees of injury, due process demands that they be permitted to "decide *for themselves* whether to tie their fates to the class representatives' or go it alone – a choice Rule 23(b)(2) does not ensure that they have." *Dukes*, 564 U.S. at 364.

264 (3d Cir. 2011) ("[A] (b)(2) class may require more cohesiveness than a (b)(3) class.").

As the Eighth Circuit has noted, a proposed class does not satisfy Rule 23(b)(2) simply because the plaintiffs allege uniform conduct or because a "determination regarding [the defendant's] liability, in the broad sense, ***could*** impact the entire class as a whole." *Ebert*, 823 F.3d at 481. If the proposed class members' claims involve "disparate factual circumstances," and "individual proof [will be] necessary to resolve" their allegations, the class is not cohesive and certification is improper. *Id*. In addition, Rule 23(b)(2) classes, like Rule 23 (b)(3) classes, must be manageable – i.e., there cannot be so many individualized issues that a jury would become overwhelmed and confused. *See St. Jude*, 425 F.3d at 1121-22.

Plaintiffs cannot satisfy any of these requirements, for the reasons set forth below.

II. BOTH PROPOSED CLASSES FAIL BECAUSE LEGAL VARIATIONS PRECLUDE A FINDING OF PREDOMINANCE OR COHESIVENESS.

The law is well established in the Eighth Circuit that nationwide medical-monitoring class actions are not certifiable because different states' laws will govern the proposed class members' claims depending on where they live and/or allege injury – and medical-monitoring law varies widely from jurisdiction to jurisdiction, creating a huge number of individualized legal issues that would make a class trial unmanageable.

For example:

- In *St. Jude*, 425 F.3d at 1122, the Eighth Circuit reversed certification of a nationwide medical-monitoring class. According to the court, fundamental "[d]ifferences in state laws on medical monitoring" – including the

elements triggering liability for monitoring – made certification improper. *Id.*

- In *Foster*, 229 F.R.D. at 605-06, the court denied plaintiffs' motion for certification of a nationwide class of heart bypass patients seeking medical monitoring after finding that the law of the state where each proposed class member was allegedly injured applied to his or her claims. Because "claims for medical monitoring are not treated uniformly among the states," there were "a 'myriad of individual legal issues that defeat[ed] the predominance requirement' and ma[de] certification 'totally unmanageable and inefficient.'" *Id.* (citation omitted).

- In *In re Prempro Products Liability Litigation*, 230 F.R.D. 555, 562, 569 (E.D. Ark. 2005), the court refused to certify a medical-monitoring class based on a finding that the laws of the 24 states in which plaintiffs resided would apply to their claims, noting that those states "indisputably address[ed] medical monitoring in a number of ways," "creat[ing] a myriad of individual legal issues" that would "swamp" any possible cohesion of the class. *Id.*

- And in *In re Baycol Products Litigation*, 218 F.R.D. 197, 207, 212 (D. Minn. 2003), the court rejected certification of a medical-monitoring class, finding that the law of the state in which the plaintiff resides would govern his or her claims and rejecting plaintiffs' argument that "the differences in state law [governing medical-monitoring claims] should not preclude class certification." *Id.*[31]

Undeterred by controlling law rejecting nationwide medical-monitoring class actions, plaintiffs ask the Court to certify not just a nationwide class, but an international class that includes retired players residing in Canada and other countries. Yet, the breadth of plaintiffs' proposed class is not the most remarkable part of plaintiffs' request.

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[31] *See also In re Rezulin Prods. Liab. Litig.*, 210 F.R.D. 61, 74 (S.D.N.Y. 2002) (noting that variations in state law are particularly inimical to class treatment of medical-monitoring claims because many state supreme courts have never addressed medical monitoring, and courts faced with such proposals are thus placed in "the undesirable position of attempting to predict how their courts of last resort would resolve that issue"). .

Even more remarkably, plaintiffs ask the Court to apply New York law to some elements of their negligence claims and Minnesota law to other elements ***of those very same claims.***

The reason for this bizarre choice-of-law request is an opportunistic one. Most plaintiffs proposing nationwide classes ask the presiding court to apply the defendant's home state's law, even though such requests have been routinely dismissed out of hand. *E.g.*, *In re Bridgestone/Firestone, Inc.*, 288 F.3d 1012, 1016 (7th Cir. 2002) (noting that no state "has applied a uniform place-of-the-defendant's-headquarters rule" to choice-of-law questions and rejecting class treatment in part on this ground; "it is state law rather than a quest for efficiency in litigation … that controls") (cited in *Baycol*, 218 F.R.D. at 207 as consistent with Eighth Circuit law). But here, the NHL is based in New York, and a few years ago, New York's highest court ***rejected*** medical-monitoring claims absent evidence that a claimant has been diagnosed with, or is under investigation by a physician for, a specific disease. *See Caronia v. Philip Morris USA, Inc.*, 5 N.E.3d 11, 14 (N.Y. 2013). In other words, plaintiffs seek to pursue claims that are barred by the law of the NHL's home state. As a result, plaintiffs are asking the Court to apply New York law with respect to the duty and breach elements of their claims and Minnesota law with respect to exposure, causation and damages. (Zimmerman Letter at 2.) Every aspect of this results-oriented choice-of-law proposal is contrary to established law.

A. Plaintiffs' Proposal To Apply New York Tort Law To The Entire Class Is Contrary To Choice-Of-Law Principles.

Plaintiffs first contend that "Minnesota's choice-of-law rules indicate that the Court should apply New York's negligence duties to govern the NHL's conduct relevant to all Class members' claims." (Mem. 49.) Even if the NHL had been based in New York throughout the class period – ***and it was not*** – this statement is false. *See, e.g.*, *Baycol*, 218 F.R.D. at 207 (holding that the "law of the state in which the plaintiff resides will govern the [plaintiff's tort] claim," not the state where the defendant is headquartered; "[t]he Eighth Circuit … has not given the [domicile] of the corporate defendant much weight in tort cases"); *Nelson v. Delta Int'l Mach. Corp*., No. 05-63(DSD/JJG), 2006 WL 1283896, at *4 (D. Minn. May 9, 2006) ("the court attributes little weight to the domicile of a corporate defendant" under Minnesota's choice-of-law rules).

Minnesota employs a three-step choice-of-law analysis. *See Blake Marine Grp. v. CarVal Inv'rs LLC*, 829 F.3d 592, 595 (8th Cir. 2016). "The first two steps inquire whether differing state laws present an 'outcome-determinative' conflict and whether each law 'constitutionally may be applied to the case at hand.'" *Id.* (citation omitted). "The third step then requires a multifactored test to consider the '(1) predictability of result; (2) maintenance of interstate and international order; (3) simplification of the judicial task; (4) advancement of the forum's governmental interest; and (5) application of the better rule of law.'" *Id.* (citation omitted).

There can be no question that there are outcome-determinative conflicts between the laws of New York and the other 49 states, the District of Columbia, and the Canadian provinces with respect to negligence, negligent misrepresentation and medical monitoring, as set forth in detail in section II.C, below. Accordingly, a true conflict exists, requiring application of Minnesota's five choice-influencing factors. As set forth below, these factors point to either: (1) the state where the players lived when they played; or (2) for players whose careers did not center around a particular team, the state where they now live in their retirement. *See Dryer v. NFL*, No. 09-2182 (PAM/AJB), 2013 U.S. Dist. LEXIS 156712, at *17-20 (D. Minn. Nov. 1, 2013), *aff'd sub nom. Marshall v. NFL*, 787 F.3d 502, 514 (8th Cir. 2015).

Predictability of Result. "The Minnesota Supreme Court has directed courts to consider the predictability of the results factor in order to 'fulfill the parties' justified expectations.'" *Dryer*, 2013 U.S. Dist. LEXIS 156712, at *17-18 (citation omitted). "This factor concerns whether the choice of law was predictable ***before*** the time of the transaction or the event which gives rise to the cause of action." *Erickson v. Hertz Corp.*, No. 05-1690, 2006 U.S. Dist. LEXIS 20818, at *10-11 (D. Minn. Apr. 14, 2006) (emphasis added). In other words, the Court must consider each putative class member's and the NHL's expectations about what law might apply to any injuries received by each plaintiff during his NHL career. Plaintiffs claim that because "[c]lass members experienced numerous head impacts in dozens of fortuitous NHL locations all over the U.S. and Canada[,]" "both Class members and the NHL could have predicted that New

York law" would govern "based on the NHL's headquarters in New York[.]" (Mem. 50.) This argument is baseless.

Although the NHL is ***currently*** headquartered in New York, it was headquartered in Montreal from 1917 until 1977. (Dep. of D'Arcy Jenish 203:19-204:20 (Ex. 54).) Over 1,000 retired, living NHL players, including Larson (SAC ¶60), joined the NHL, and played at least a portion of their careers, while the NHL was headquartered in Canada. *See* National Hockey League Official Guide & Record Book 2016, 612-662 (Ex. 55). And more than 600 retired, living NHL players played ***all*** of their NHL games while the League was based in Canada, as did Zeidel. (*Id*.) These putative class members would have had no reason to expect New York law to apply to their claims.

Even players who joined the League after its relocation to New York would have expected that the jurisdiction where they lived and presumably played all their home games governed any tort claims that would arise from playing NHL hockey. As the *Dryer* court recognized in analogous circumstances, "[w]here Plaintiffs played in various locations, for teams located throughout the United States [and Canada], it is likely that they would have expected that the vindication of their … rights would be subject to the law where their team was located or where they themselves lived." *Dryer*, 2013 U.S. Dist. LEXIS 156712, at *18. "Thus, the predictability-of-results factor would favor the law of the many different states in which Plaintiffs played and lived" – not New York. *Id.*

Maintenance of Interstate and International Order. "This factor requires that the state whose laws are applied have sufficient contacts with the facts in issue." *Id.* As

other courts have recognized, "the interstate-order factor favors the application of the law of states closely connected to Plaintiffs, such as the home state of their team(s) or their own homes." *Id.* Thus, this factor either favors application of the laws of the state(s) of each player's team(s) or is neutral. *See id.* at *19 ("[A]t best this factor is neutral in the choice-of-law analysis.").

Simplification of the Judicial Task. While plaintiffs are correct that this factor is generally treated as neutral (*see* Mem. 51), "where it is possible that the law of many different states may apply to Plaintiffs' claims, this factor highlights the unmanageability of the class action apparatus." *Dryer*, 2013 U.S. Dist. LEXIS 156712, at *19. Those concerns are clearly present here because plaintiffs' putative class involves more than 5,100 individuals, who reside throughout the United States and Canada (and a small number in other countries as well).

Advancement of the Forum's Governmental Interest. Courts must also "determine which state's law to apply based on 'the relative policy interests of the two states.'" *Blake Marine Grp.*, 829 F.3d at 596 (citation omitted). Plaintiffs argue that this factor favors application of New York law because the NHL's alleged negligence occurred at "its principal place of business," and in such cases, "New York 'has the greatest interest in regulating behavior within its borders.'" (Mem. 51 (citation omitted).) This argument fails for at least two reasons.

For one thing, as set forth above, the NHL's principal place of business was in Montreal until 1977. Therefore, under plaintiffs' own theory, any alleged negligence by the NHL before that time occurred in Montreal – not New York. (*See id.*) In addition,

the Eighth Circuit has repeatedly held that this factor does ***not*** favor application of the laws of a corporate defendant's home state when the plaintiff resides elsewhere. *See Blake Marine Grp.*, 829 F.3d at 596 ("[A] forum state's 'interest in having its product liability laws enforced against its own corporate residents' d[oes] not support application of its law [where] the plaintiff [i]s a nonresident.") (quoting *Hughes v. Wal-Mart Stores, Inc.*, 250 F.3d 618, 621 (8th Cir. 2001)). Instead, it heavily favors application of the law of the state in which each retired player resides (which, in a significant number of cases, will be the same state in which the player spent the majority of his career). To the extent a putative class member's career did not center around a particular team, or he has long resided elsewhere, the place of that player's current residence would have the greatest interest.[32] As the Eighth Circuit has explained, "[c]ompensation of an injured plaintiff is primarily a concern of the state in which [the] plaintiff is domiciled." *Blake Marine Grp.*, 829 F.3d at 596 (citation omitted); *see also, e.g.*, *In re St. Jude Med., Inc. Silzone Heart Valve Prods. Liab. Litig.*, No. MDL 01-1396 JRTFLN, 2003 WL 1589527, at *9-10 (D. Minn. Mar. 27, 2003) ("although St. Jude is located in Minnesota and many decisions regarding the [product] were made in th[e] state," Minnesota's "significant interests in

[32] The varying course of each putative class member's career only underscores the complexity of the choice-of-law problem. Individualized inquiries would be necessary to determine which forum has the strongest connection to each putative class member's claims given the different courses a professional hockey career can take, with some players spending most of their career on one team and others moving around.

applying its law to th[e] case" did not overcome the "interests of states in which class members" were purportedly injured), *rev'd on other grounds*, 425 F.3d 1116.

***Application of the Better Rule of Law*.** This factor generally applies only if the first four factors do not resolve the choice-of-law question. Because each of the above factors either favors application of the law of the state in which each putative plaintiff lives or played or is neutral, the Court need not consider it. *See Dryer*, 2013 U.S. Dist. LEXIS 156712, at *20.

In short, Minnesota's choice-of-law rules do not – as plaintiffs contend – permit the Court to uniformly apply New York law to the tort claims of all retired NHL players across the United States and Canada. Instead, they require a plaintiff-by-plaintiff determination that will point to the place where the plaintiff lived during most of his career and/or during retirement.

B. Plaintiffs' Proposal To Apply Minnesota Medical-Monitoring Law To The Entire Proposed Class Is Even More Flawed.

Even if plaintiffs' proposal to apply New York law to the entire class had any legal support, their proposal that the Court apply two different states' laws to each plaintiff's negligence claims is even more offensive to fundamental choice-of-law principles. Plaintiffs argue – with no legal support – that "because Minnesota treats medical monitoring as a remedy for negligence," Minnesota medical monitoring law should govern every proposed class member's entitlement to monitoring, regardless of where he played or resides. (Mem. 48.) This result-oriented proposal would abrogate longstanding choice-of-law principles.

Although Minnesota law provides that matters of "procedures and remedies" are governed by the law of the forum, *Zaretsky v. Molecular Biosystems, Inc.*, 464 N.W.2d 546, 548 (Minn. Ct. App. 1990) (Mem. 46-47), that does not transform the right to receive medical-monitoring relief – an issue on which the states differ greatly – into a procedural issue that is governed by the law of the forum. *See Nesladek v. Ford Motor Co.*, 46 F.3d 734, 736 (8th Cir. 1995) (the fact that other potentially applicable state laws see an issue as one of "substantive law" weighs against a finding that the issue is procedural or remedial for choice-of-law purposes). To the contrary, Minnesota appellate courts have made clear that damages are considered substantive in nature when they are "designed to make the plaintiff whole" and affect "the underlying matter in dispute," which is plainly the case with medical-monitoring relief. *Zaretsky*, 464 N.W.2d at 550;[33] *Chesapeake & Ohio Ry. Co. v. Kelly*, 241 U.S. 485, 491 (1916) (observing that the "proper measure of damages is inseparably connected with the right of action"); *see also, e.g., Dodds v. St. Jude Med. Inc.*, Nos. C3-04-10613, C3-04-1619, 2005 WL 6336316 (Minn. Dist. Ct. Oct. 20, 2005) (concluding that a damages cap was substantive rather than procedural/remedial and applying Canadian law instead of Minnesota law).

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[33] *Zaretsky* determined that Minnesota's prejudgment interest statute was procedural because although interest is a form of damages and in that sense "substantive," the interest was "merely one effect of the procedural purpose of the statute, which is to encourage settlements." 464 N.W.2d at 550-51. Medical monitoring, by contrast, is a form of substantive relief "designed to make the plaintiff whole" based on "the underlying matter in dispute." *Id.* at 550.

This is particularly true here given plaintiffs' assertion that key elements of their substantive causes of action – including injury and causation – are part of the medical-monitoring "remedy." (*See* Zimmerman Letter at 2 (insisting that only the elements of "Duty + Breach" are governed by New York law, while "Exposure + Causation of Cell Damage + Increased Risk" are controlled by Minnesota law).) In other words, this is not merely a matter of remedy; injury and causation are substantive elements of plaintiffs' claims that they seek to adjudicate under Minnesota law, because they perceive it as favorable to their claims.

Not surprisingly, plaintiffs ***do not cite a single case*** (from Minnesota or elsewhere) holding that entitlement to medical monitoring is a procedural issue controlled by the law of the forum. (Mem. 48.) For example, plaintiffs cite *Werlein v. United States* for the proposition that "'medically appropriate monitoring is simply a future medical cost'" (*id.* (citing 746 F. Supp. 887, 904-05 (D. Minn. 1990)), but *Werlein* said nothing about the supposed implications of that fact for ***choice of law*** and is thus irrelevant. *See* 746 F. Supp. at 904-05.[34] By contrast, as set forth above, a long line of courts within the

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[34] Plaintiffs also rely on *In re Levaquin Products Liability Litigation*, MDL No. 08-1943 (JRT), 2010 WL 7852346 (D. Minn. Nov. 9, 2010), but there, the issue was which state's punitive damages law to apply. Punitive damages are fundamentally different from medical monitoring because they are available only ***after*** entitlement to actual or compensatory damages is established. Medical monitoring, by contrast, is a form of compensatory damages that is intimately intertwined with the underlying tort. Moreover, the *Levaquin* court also went on to consider Minnesota's choice-influencing factors and found that those factors weighed in favor of applying Minnesota law. *Id.* at *8-9. By contrast, here, the factors point to each proposed class member's state of residence. In any event, other courts have declined to follow Levaquin's approach in cases involving *(cont'd)*

Eighth Circuit have treated medical monitoring as a substantive issue requiring a choice-of-law analysis. *See, e.g.*, *Foster*, 229 F.R.D. at 602, 605 (recognizing that "the laws of the fifty states" would have to be applied in suit requesting medical-monitoring relief). Indeed, plaintiffs' own cases take this approach. Plaintiffs rely on *In re St. Jude*, 2003 WL 1589527, at *10, *15, for the proposition that "medical monitoring [i]s a form of ***equitable*** relief under Minnesota law[.]" (Mem. 48 (emphases altered).) But that court ***did not*** find that medical monitoring was a procedural issue, and instead performed a substantive choice-of-law analysis to determine applicable law. 2003 WL 1589527, at *15. According to the court, "other states have consciously developed different standards for medical monitoring, or have not adopted such an action at all," and "[t]hese states' interests in applying their laws to the … industry within their borders is at least as strong as Minnesota's interest in doing so." *Id.* Thus, the court concluded that "Minnesota's governmental interests do not outweigh those of other states, and the Court will apply the law of the state in which each class member's claim arose to all members of the [Rule 23(b)(2) medical] monitoring class." *Id.*[35]

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non-Minnesota plaintiffs. *See Burke v. DJO, LLC*, No. 10-cv-2209 (JRT/TNL), 2012 WL 383948, at *3-4 (D. Minn. Feb. 6, 2012) ("[Minnesota]'s procedure should not be employed to obtain relief in one forum not otherwise available in another.").

[35] On appeal, the Eighth Circuit reversed the district court's certification of a Rule 23(b)(2) medical-monitoring class but implicitly agreed with the district court's conclusion that the medical-monitoring issue is a substantive one subject to ordinary choice-of-law principles. *See St. Jude*, 425 F.3d at 1122 ("Proposed medical monitoring classes suffer from cohesion difficulties, and numerous courts across the country have

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Application of Minnesota medical-monitoring law to every retired NHL player would also run afoul of due process and the Rules Enabling Act. 28 U.S.C. § 2072(b). With respect to due process, plaintiffs have the burden of demonstrating that Minnesota has "a 'significant contact or significant aggregation of contacts' to the claims asserted by each member of the plaintiff class." *Phillips Petrol. Co. v. Shutts*, 472 U.S. 797, 821-22 (1985) (citation omitted). Plaintiffs cannot meet that burden because Minnesota has ***zero*** connection to the majority of the proposed class members. Although plaintiffs assert that some NHL games were played in Minnesota between 1967-1993 and 2000-present, and some players were drafted from Minnesota cites and universities between 1994-1999 (*see* Mem. 43-44), these minimal contacts are insufficient to justify the application of Minnesota law to non-Minnesota residents alleging that they sustained injury playing in NHL games across the U.S. and Canada. *See, e.g.*, *Cruz v. Lawson Software, Inc.*, No. 08-5900 (MJD/JSM), 2010 WL 890038, at *8-9 (D. Minn. Jan. 5, 2010) (rejecting the "blanket application of Minnesota law [as] unconstitutional" where the vast majority of putative class members were not Minnesota residents and the plaintiffs failed to proffer "strong connections" of those non-resident class members to Minnesota). This is especially true because ***no NHL team was based in Minnesota*** between 1993 and 2000.

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denied certification of such classes. … Differences in state laws on medical monitoring further compound these disparities.") (citations omitted).

Plaintiffs' proposal would also violate the Rules Enabling Act by attempting to supplant the highly varying approaches to medical monitoring of the fifty states with a single state's law. *In re Diet Drugs (Phentermine, Fenfluramine, Dexfenfluramine) Prods. Liab. Litig.*, No. 98-20626, 1999 WL 673066, at *14 (E.D. Pa. Aug. 26, 1993) (Mem. 41, 57) (using Rule 23 "as the conduit through which Pennsylvania's medical monitoring cause of action extend[s] to all class members" would violate Rules Enabling Act). This is particularly troubling because many states do not permit medical monitoring absent a showing of present personal injury (and because no Canadian court has recognized the validity of medical-monitoring claims on the merits). (*See generally* Decl. of John B. Laskin ¶¶12-33 (Ex. 56); Decl. of Sylvie Rodrigue ¶¶8-9 (Ex. 57).)[36] Thus, if plaintiffs' approach were accepted, people from all over North America would flock to Minnesota district courts with medical-monitoring claims that would be rejected under the laws of their home states or provinces. *Cf. also Nesladek*, 46 F.3d at 738 (noting that forum-shopping concerns weigh against characterizing a law as non-substantive for choice-of-law purposes).

For all of these reasons, plaintiffs' choice-of-law proposal should be rejected.

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[36] As set forth in these declarations, a number of Canadian courts have expressed deep skepticism of medical-monitoring claims in part because of Canada's publicly-funded healthcare system.

C. State-Law Variations Make A Classwide Finding Of Liability On Any Of Plaintiffs' Claims Impossible – And Plaintiffs' State-Law "Grouping" Proposal Does Not Solve This Problem.

Plaintiffs concede that if the Court rejects their choice-of-law proposal, they cannot obtain class certification with respect to their negligent misrepresentation claim because state-law standards with respect to that cause of action vary significantly. (*See* Zimmerman Letter at 3.) What they fail to acknowledge, however, is that the same is true of their other causes of action.

"The law of negligence, including subsidiary concepts such as duty of care, foreseeability, and proximate cause" differs among the states in "important" ways that preclude nationwide class certification. *In re Rhone-Poulenc Rorer Inc*., 51 F.3d 1293, 1300 (7th Cir. 1995); *see also Baycol*, 218 F.R.D. at 208 (denying certification of proposed nationwide class asserting a negligence claim because differences in state law defeated predominance and superiority); *Foster*, 229 F.R.D. at 605 (explaining that "the application of the laws of the fifty states makes class treatment of [*inter alia*, plaintiffs' negligence claim] unwarranted").

Courts have also repeatedly recognized that medical-monitoring laws vary significantly, making it impossible to certify multi-state medical-monitoring classes. *See, e.g., St. Jude*, 425 F.3d at 1122; *see also, e.g., Zehel-Miller v. AstraZeneca Pharm., LP*, 223 F.R.D. 659, 663 (M.D. Fla. 2004) ("'Many states never have recognized a claim for medical monitoring,'" and "'[t]hose states that have done so have adopted widely varying criteria for recovery.'") (citation omitted); *Rezulin*, 210 F.R.D. at 75 ("[T]he prerequisites to, and the availability *vel non* of, medical monitoring vary from state to state and

therefore among the members of the subclass."). As one court noted, a nationwide class trial of medical-monitoring claims would be utterly unmanageable because "instructing the jury [regarding the different applicable laws] in a manner that is both legally sound and understandable to a jury of laypersons would be a herculean task," requiring a "verdict form [that] would read more like a bar exam." *Harding v. Tambrands Inc*., 165 F.R.D. 623, 632 (D. Kan. 1996).

Plaintiffs argue that even if the Court rejects their novel choice-of-law approach, certification is appropriate despite the many differences in states' laws because they have identified groups of states where "the elements of common-law negligence and medical-monitoring relief ... are ***nearly identical*[**.]" (Mem. 35 & n.179 (emphasis added); *see also* Pls.' Exs. 141-42.) But plaintiffs' grouping analysis grossly oversimplifies the laws at issue or simply misstates them.

With respect to their negligence claims, plaintiffs group together 48 jurisdictions that they assert have "nearly identical" standards for determining whether a duty to warn exists. (*See* Mem. 35 & n.179; Pls.' Ex. 142 (categorizing 47 states and Washington, D.C., as jurisdictions that would find a duty of care when there is a "foreseeable risk of injury to a foreseeable plaintiff").) But the law is not so simple or consistent. For example, some states impose a duty to warn only if the alleged risk is foreseeable; in other states, foreseeability is merely one factor among many to be considered; and in still other states, foreseeability is not considered at all. (*See* Ex. 58.) In addition, as explained in detail in Exhibit 58, the negligence laws of these states also vary in many other material respects, including:

- **Express Assumption of Risk**: Some states, including Florida, hold that a general waiver of "any liability" or "all claims" bars negligence claims. By contrast, other states, including Missouri, have held that a release of liability only precludes negligence claims if it actually uses the word "negligence" or a synonymous term. Still other states, including Louisiana, do not recognize express assumption of risk at all.

- **Implied Assumption of Risk**: Some states, including Massachusetts, consider a plaintiff's implied assumption of risk as part of their comparative-fault schemes, while Washington, D.C. and other jurisdictions view it as a separate affirmative defense. North Carolina does not recognize implied assumption of risk at all.

- **Contributory Negligence and Comparative Fault**: Four states and Washington, D.C. have adopted a system of pure contributory negligence, which bars a plaintiff from recovery if he is found to have contributed to his alleged injuries. A number of other states, including New York, have adopted pure comparative fault regimes that allow plaintiffs to recover for the amount of their injury that is deemed to be the fault of the defendant. Still other states, such as Nevada and Pennsylvania, have modified comparative fault schemes, where plaintiffs are barred from recovery if the plaintiff is 51% or more at fault.

- **Allocation of Fault to Nonparties**: Some states, such as Minnesota, allow the trier of fact to consider nonparty fault and allocate fault to parties and nonparties alike to the extent of their share of fault. In other jurisdictions, including Missouri and Massachusetts, the trier of fact may consider the fault of nonparties only if the defendant is alleging that the nonparties were the sole proximate cause of the plaintiff's injury.

Plaintiffs' insistence that there are distinct groups of jurisdictions that have "nearly identical" medical-monitoring laws (*see* Mem. 35 & n.179; Pls.' Ex. 141, Chart A) is similarly false. Plaintiffs identify 28 jurisdictions that purportedly permit medical-monitoring relief in cases where there is "a showing of exposure plus increased probability" of developing a future disease. (Pls.' Ex. 141.) But, as explained above and in Exhibit 59, these states' laws differ in important ways. For example:

- **Necessary showing of injury**: The law of some states, including New York, is clear that subcellular damage is ***not*** sufficient to establish the present injury necessary to obtain medical monitoring. By contrast, courts in states such as Massachusetts and Minnesota have held that proof of subcellular damage does establish a present injury. And in other states, including Pennsylvania, medical monitoring is an independent cause of action that does not require present injury.

- **Increased Risk of Contracting an Injury**: Some states, including Missouri, require the plaintiff to show a "significantly increased risk" of contracting a particular disease, while others, such as Utah, require only "increased risk," with no specified qualification or quantification of increased risk. Although Minnesota's highest court has not recognized a cause of action for medical monitoring, some Minnesota courts have indicated that requests for medical monitoring are akin to claims for future damages, which require proof that it is "more likely than not" that future injury will occur.

- **Proof that a Procedure Exists to Detect the Disease**: Some states, such as Florida and Massachusetts, expressly require the plaintiff to prove a procedure exists that can detect the disease. Other states, such as Arizona and Missouri, have not expressed the same requirement.

- **Whether a Treatment for the Disease Exists**: In Utah, the plaintiff must show that a treatment exists that can alter the course of the illness. Conversely, other states, such as Pennsylvania, do not require plaintiffs to show that a treatment currently exists.

For all of these reasons, individualized legal issues will substantially predominate over any supposedly common issues in this litigation.

III. INDIVIDUALIZED FACTUAL ISSUES ALSO PRECLUDE CERTIFICATION OF A MEDICAL-MONITORING CLASS.

Plaintiffs' claims also fail to satisfy the requirements of predominance and cohesiveness because they turn on highly individualized facts.

As a threshold matter, plaintiffs' efforts to create common questions through the opinions of their experts should all be rejected. As detailed in the NHL's motions to exclude Cantu, Comstock, Hoshizaki, Casper and Jenish, the opinions these witnesses

intend to offer are speculative and lack any scientific basis. Indeed, Cantu conceded that any causal connection between head trauma in sport and CTE "remains to be shown" and that his proposed white matter causal chain likewise remains theoretical – thereby undermining the opinions of plaintiffs' other experts. (Cantu Dep. 112:18-114:1, 121:12-122:11, 125:3-18, 143:6-22, 146:2-147:20, 151:10-152:4, 385:17-20.) The unreliability of plaintiffs' expert opinions alone requires denial of class certification. *See Grodzitsky v. Am. Honda Motor Co.*, No. 2:12-CV-1142-SVW-PLA, 2015 WL 2208184, at *11 (C.D. Cal. Apr. 22, 2015) (denying certification because plaintiffs' expert evidence regarding causation was unreliable).

But even if plaintiffs had any valid science to support their claims, their proposed medical-monitoring class would not be certifiable under Eighth Circuit law because determining "each plaintiff's need … for medical monitoring [would be] highly individualized." *St. Jude*, 425 F.3d at 1122; *see also, e.g.*, *Baycol* 218 F.R.D. at 213 (refusing to certify medical-monitoring class against manufacturer of prescription drug under either Rule 23(b)(2) or Rule 23(b)(3) because, *inter alia*, "the potential for future injury can only be decided by looking to the individual medical histories of the class members"); *Hood v. Gilster-Mary Lee Corp.*, No. 3:14-cv-05012-MDH, 2016 U.S. Dist. LEXIS 135475, at *20-21 (W.D. Mo. Sept. 30, 2016) (rejecting medical-monitoring class because "it present[s] too many individual and legal issues") (citation omitted); *Leib v. Rex Energy Operating Corp*., No. 06-cv-802-JPG-CJP, 2008 WL 5377792, at *12-13 (S.D. Ill. Dec. 19, 2008) (rejecting certification of medical-monitoring class because of

plaintiffs' "varying health backgrounds" and "varying alternate exposures"); *Rhodes v. E.I. du Pont de Nemours & Co.*, 253 F.R.D. 365, 380 (S.D. W. Va. 2008) (similar).

Virtually every element of plaintiffs' claims will turn on individualized evidence, including, *inter alia*, when each player played in the NHL, the scientific information available during that time, the information he was provided by the League, the information he had from other sources (including the NHLPA), his personal history of head impacts in the NHL and other leagues, and his medical history.

A. Plaintiffs' Negligence, Negligent Misrepresentation And Medical-Monitoring Claims Will Turn On Highly Individualized Facts.

1. Evidence Relevant To The NHL's Duty To Players Varies Over Time.

Plaintiffs' claims are based on the allegation that the NHL had a duty to warn players of the "neurological risks of head injuries suffered while playing hockey in the NHL." (SAC ¶¶433, 439.) In addition, plaintiffs assert that the NHL has voluntarily "[a]ssumed a [d]uty of [c]are to [p]rotect" all NHL players "throughout its existence" by undertaking to study various safety issues, including concussions, and "creat[ing] a program and working group specifically to collect and analyze data on concussions[.]" (Mem. 62-63 (emphasis removed); *see also* SAC ¶431.) But whether the NHL had a duty to warn or protect each player will depend on the NHL's knowledge, actions and statements during that player's career.

a. The Existence Of A Duty To Warn Would Turn On Different Evidence Depending On When A Putative Class Member Played In The NHL.

Although states apply varying standards to determine when a duty to warn arises, as set forth in Exhibit 58, every state's laws would require a jury faced with claims of negligence to consider the NHL's knowledge at the relevant time regarding the risk alleged by plaintiffs.[37] Here, knowledge regarding the purported long-term risks of head hits, including NDDCs, has evolved significantly over time, as discussed above (*see* pp. 6-20, *supra*). Accordingly, there is no way for a jury to decide – based on common evidence – whether the NHL had a duty to warn all proposed class members, who played in the NHL at different times, about the varying risks alleged in plaintiffs' Complaint.

For example, the evidence potentially relevant to whether the NHL had a duty to warn Zeidel, who retired from the League in 1969, would be limited to isolated clinical case reports of dementia pugilistica or CTE in boxers that were published before that time. By contrast, in a trial of the claims of Leeman, who played between 1983 and 1996, plaintiffs could point to the 1973 case series by Corsellis and other literature published after Zeidel retired. And by further contrast, in a trial involving putative class

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[37] *See, e.g.*, *Quinonez v. Manhattan Ford, Lincoln-Mercury, Inc*., 62 A.D.3d 495, 497 (N.Y. App. Div. 2009) ("Generally, liability for failure to warn may exist only where there is a known danger or a danger the defendant has reason to be aware of."); *Tuttle v. Lorillard Tobacco Co.*, 377 F.3d 917, 924 (8th Cir. 2004) (to establish a duty to warn under Minnesota law, the plaintiff must show that "the defendants had reason to know of the dangers" to the plaintiff).

members who played after 2005, plaintiffs would likely try to argue that the NHL should have been aware of Omalu's case report of CTE in a retired football player.

Plaintiffs assert that "numerous documents" show that the NHL knew about the "long-term risks" of head injuries (Mem. 14-18) – but all of the documents they cite for that proposition are from 2007 or later (*see* Pls.' Exs. 79-95). Such evidence would be irrelevant and inadmissible with respect to the claims of any player who retired before that time, including Leeman, Christian, Nicholls and Zeidel, further highlighting the individualized nature of their claims. *See Baycol*, 218 F.R.D. at 208 (denying certification of negligence claims; "whether there is a breach of duty or the foreseeability of harm will depend on what Defendants knew or should have known at the time Baycol was prescribed and whether Defendants acted reasonably based on the knowledge [they] had ***at that time***") (emphasis added).[38]

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[38] In addition, even if a jury were to determine that the NHL had reason to be aware that scientists were investigating potential long-term risks of concussions at the time a particular proposed class member was playing, it would also have to determine exactly what information the NHL was required to disclose at that time given the immaturity of the science. [redacted] The same concerns arise with respect to telling players that they are likely to develop debilitating conditions like Parkinson's disease or ALS.

b. Whether The NHL Voluntarily Assumed A Duty To Protect Each Putative Class Member Will Turn On Evidence That Varied Over Time.

Plaintiffs also appear to base their negligence claims on a theory that the NHL "voluntarily assumed" a separate "duty of care" by virtue of its "broad authority" as the "steward of the league" to govern League play and its "vastly superior managerial, medical, legal and other resources[.]" (Mem. 62.) But in order to establish voluntary assumption of a duty under many states' laws, each putative class member would have to prove that he relied on an action by the NHL that left him in a worse position than he would have been in if the NHL had done nothing.[39] Plaintiffs fail to identify any affirmative action taken by the NHL on which all players at all times relied to their detriment and that increased their risk of injury. The closest plaintiffs come is their assertion that the NHL undertook "to survey injuries, including concussions" and "analyze data on concussions[.]" (*Id.* 63.) This theory is illogical because plaintiffs fail to explain how the NHL's efforts to study player safety placed players in a more vulnerable position. But even if plaintiffs' theory were viable, each class member would

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[39] *See, e.g.*, *Heard v. City of N.Y.*, 623 N.E.2d 541, 544 (N.Y. 1993) (plaintiffs must prove reliance and that the "defendant's conduct placed plaintiff in a more vulnerable position than plaintiff would have been in had defendant done nothing"); *Funchess v. Cecil Newman Corp.*, 632 N.W.2d 666, 674 (Minn. 2001) (a party voluntarily assumes a duty if he "'increases the risk of … harm'" or "'the harm is suffered because of the [plaintiff's] reliance upon the undertaking'") (citation omitted); *Manfre v. Shinkle*, 184 So. 3d 641, 649 (Fla. Dist. Ct. App. 2016) (plaintiff failed to show any breach of an assumed duty because the defendant "did not increase any zone of risk" and the plaintiff did not rely on any act by the defendant).

have to individually prove that he relied to his detriment on the NHL's safety efforts at the time he was playing. This is not possible on a classwide basis, both because of the inherently individualized nature of reliance ***and*** because the NHL's conduct changed during the class period.

While the NHL has collected data regarding player injuries since the 1970s, the League's effort to collect and analyze concussion-related information began in 1997 with the development of the NHL/NHLPA Concussion Program. (Daly ¶¶108, 111-14.) Further, since the Program was created, the NHL and the NHLPA's efforts to identify and address the most frequent causes of head injuries, including concussions, have continued to evolve, as discussed above. (*See* pp. 20-27, *supra*.) Accordingly, even if plaintiffs' theory were accepted, the evidence relevant to whether the NHL assumed a duty to a particular player will depend on when the player played in the League and the NHL's specific conduct at that time. For example, to the extent plaintiffs assert that the NHL voluntarily assumed a special duty by virtue of creating the Concussion Program, that duty would not apply to putative class members, who, like Christian, Leeman and Zeidel, retired ***before*** the Concussion Program began. This too makes certification of plaintiffs' claims improper.

2. <u>The Evidence Relevant To The Breach Element Of Each Putative Class Member's Claims Will Vary Depending On When He Played.</u>

Whether the NHL "[b]reached its [d]uties by [f]ailing to [w]arn" of the alleged risk of NDDCs (Mem. 63 (emphasis removed)) will also turn on a host of individualized questions. As set forth above, the science regarding an alleged link between mTBI and

NDDCs remains nascent for some NDDCs and non-existent for others. Nevertheless, the NHL has worked with the NHLPA to provide information and warnings regarding the potential risks of head injuries to players over time, and the content of those statements has evolved. As set forth above, such information includes: a 1997 joint letter to players about repeated minor brain injuries; a 2002 educational video warning players that "injuries to the head can end hockey careers and can adversely affect a player's life and lifestyle after hockey"; locker room notices in 2008 warning players that failing to report concussion-related "symptoms may lead to extended time loss, ending your career and permanent brain damage"; a 2008 video warning that "a concussion you get now could have long-term lasting effects that can be with you the rest of your life"; a 2013 Rookie Orientation Program educating players about concussions and their potential long-term effects, including CTE; and a 2015 educational video noting that "[s]ome researchers have suggested a relationship exists between head impacts in sport and CTE." (*See* pp. 24-25, *supra*.) In light of the NHL's evolving statements, the evidence relevant to each putative class member's claims will again vary depending on when he played, what information was given to him by the League at that time, and whether that information was consistent with the then-current state of science, further precluding class treatment of plaintiffs' claims. *See Baycol*, 218 F.R.D. at 208.

In addition, because plaintiffs allege that the NHL breached a separate, voluntarily assumed duty to protect players by "creating, fostering, and promoting a culture of extreme violence, including head hits and violence from fighting" (SAC ¶¶430-34), plaintiffs would have to prove that this was the case at the time each proposed class

member was playing. Although the NHL's power to adopt rules is limited by the CBA, the NHL has taken different steps over time to significantly limit violence and fighting in the League and has worked with the NHLPA to improve player safety via rule changes over time. As discussed above (*see* pp. 25-27, *supra*), this has included altering the supplemental discipline standard to impose more severe consequences for illegal hits intentionally delivered to opponents' heads; adopting and modifying an on-ice penalty prohibiting certain hits to opponents' heads; adopting rules targeted at players who instigate fights; proposing a rule (opposed by the NHLPA) intended to eliminate "staged fights"; and adopting rules mandating visors and requiring players to keep helmets on during fights. Because different players were subject to different rules depending on when they played in the NHL, the evidence relevant to whether the NHL breached any purported duty will vary from one putative class member to another, further precluding certification.

3. Each Putative Class Member's Ability To Establish Injury Traceable To Head Hits Will Turn On Individualized Evidence.

As set forth above and in Exhibit 59, some states only allow recovery for medical monitoring if the plaintiff can prove all of the elements of a substantive tort claim, including present "diagnosable" injury. *See, e.g.*, *Caronia*, 5 N.E.3d at 17. In other states, courts have found that evidence of subcellular damage is sufficient to make a showing of injury. *See, e.g.*, *Bryson v. Pillsbury Co.*, 573 N.W.2d 718, 721 (Minn. Ct. App. 1998). Still other states have recognized a distinct medical-monitoring cause of action that allows recovery without present injury, as long as a number of other

requirements – including significant exposure and a significantly increased risk of harm – are satisfied. *See, e.g.*, *Petito v. A.H. Robins Co.*, 750 So. 2d 103 (Fla. Dist. Ct. App. 2000); *Redland Soccer Club, Inc. v. Dep't of Army*, 696 A.2d 137, 145-46 (Pa. 1997). Thus, under any of the potentially applicable states' laws, plaintiffs will have to make some showing that each proposed class member has been injured or is at an increased risk of injury. This too will require individualized, plaintiff-specific evidence.

a. Plaintiffs Cannot Prove Present Injury Based On Common Evidence.

Plaintiffs assert that all proposed class members have been uniformly injured because they sustained "subcellular … injury" in the form of "white matter damage[.]" (Mem. 53-54.)

Even assuming this theory were scientifically valid, it would be legally insufficient under the laws of states, like New York, that require a diagnosable injury to obtain medical monitoring. *See, e.g.*, *Caronia*, 5 N.E.3d at 18 (noting that only "[]***symptomatic*** plaintiffs" and those actually diagnosed with an illness have a legitimate claim that they have been injured) (emphasis added); *Duncan,* 203 F.R.D. at 613 (denying motion for class certification because "[t]he evidence of alleged 'present injury' would necessarily differ according to each plaintiff and would require examination of the individual's medical records to establish that injury does indeed exist"). Instead, proving injury under these states' laws would require player-by-player determinations of each proposed class

member's medical condition and whether he has suffered symptomatic injury or an illness from head hits.[40]

Proving injury would be no less complicated under the laws of states that recognize subcellular damage as injury. As courts applying such laws have noted, whether each proposed class member actually has subcellular injury is an individualized issue that cannot be resolved jointly. *See, e.g.*, *Thompson v. Am. Tobacco Co.*, 189 F.R.D. 544, 556 (D. Minn. 1999) (denying class certification of medical-monitoring claims under Minnesota law because injury cannot be proven "without eventually engaging in individual inquiries"). This case is no different.

While plaintiffs assert that all former NHL players necessarily have subcellular damage in the form of "white matter" loss by virtue of having played in the NHL (*see* Mem. 26-27), there is no reliable science to support this theory. Plaintiffs' subcellular theory of injury is based on the expert report of Hoshizaki, who opines that the average NHL player sustains at least one head hit per two games that causes strain "above the minimum threshold for causing white matter damage[.]" (*See* Cantu ¶57; *see also* Hoshizaki ¶¶14, 59.) But Hoshizaki's opinion does not rely on studies involving head hits or white matter loss; instead, he relies on literature in which scientists have produced certain cellular changes by straining cells in giant squids, the optic nerves of guinea pigs

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[40] Notably, one of the named plaintiffs, Christian, does not allege ***any*** present symptoms (SAC ¶58), while others – like Nicholls – allege symptoms but do not purport to have been diagnosed with an NDDC (*id.* ¶51).

and brain cell cultures of rats. (Olanow Suppl. ¶¶68-71.) As Dr. Warren Olanow, Professor and Chairman Emeritus, Mount Sinai School of Medicine, has noted, there is no "reason to believe that force applied to individual cells in a tissue culture model accurately models the force applied to individual neurons throughout the entire brain of a human." (*Id*. ¶70.) Nor is there any basis from which to conclude that cellular or subcellular damage in animal cells signifies white matter loss in the human brain. To the contrary, the notion that concussions or subconcussive impacts cause permanent changes to white matter itself remains unproven and hypothetical.[41] (*See id.* ¶¶58-82.) Further, Hoshizaki's assertion that all former NHL players have experienced hits capable of causing white matter loss is based on finite element modeling, which is merely a "research tool" that has never been validated for predicting brain injury. (Panzer ¶14; *see also* Olanow Suppl. ¶75.) Thus, plaintiffs do not have any reliable scientific evidence that any proposed class member has experienced white matter loss, much less that they all have.[42]

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[41] Nor is there an accepted method to test for white matter damage. While Cantu suggests that white matter loss can be detected using diffusion tensor imaging ("DTI") (Cantu ¶49), "DTI is an experimental methodology, and not used clinically or diagnostically for any purpose." (Randolph ¶25(d).)

[42] The NHL would also contest plaintiffs' assertion that any white matter loss experienced by proposed class members is the result of head injuries. It is "well recognized within the scientific community that white matter loss is a common and normal consequence of aging even in individuals who have no history of having had any injury to the brain." (Olanow Suppl. ¶66.) Thus, each proposed class member would have to establish that any white matter damage he claims to have sustained is the result of a head hit from NHL play – as opposed to normal aging.

b. Individualized Evidence Would Also Be Required To Establish A Significantly Increased Risk Of Injury And Other Factors Relevant To Medical Monitoring Under No-Injury States' Laws.

In states such as Pennsylvania, California and Florida that allow medical monitoring absent injury, plaintiffs are generally required to prove a variety of factors (again, varying from state to state), including significant exposure, increased risk of a latent disease and the need for medical testing that would not be required in an unexposed person. (*See* Ex. 59.) These elements, too, will turn on individualized evidence.

Each Proposed Class Member's Ability To Prove Significant Exposure Will Vary. It is well recognized that some players are more likely to experience head impacts than others based on the particular positions they played and the length of their careers. Goaltenders, for example, have a much lower incidence of head injuries than any other position.[43] Centers, on the other hand, have a higher incidence of concussion than other players.[44] Notably, a study by Navigant found that over the course of nine seasons, 70% of NHL players were not diagnosed with any concussions, and of those players who were diagnosed with any concussions during that period, 63% were diagnosed with just one. (Report of Sonya Kwon at 9-10 (Ex. J).) These sorts of variations in head-hit exposure further preclude certification. *See, e.g.*, *Ball v. Union Carbide Inc.*, 385 F.3d 713, 727-28

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[43] *See* Benson, B. et al., *A Prospective Study of Concussions Among NHL Players During Regular Season Games*, CMAJ (2011) (Ex. 60) (only 4.5% of concussed NHL players in the study were goaltenders).

[44] *Id.* ("the proportion of concussions sustained by centremen was about twice that of defencemen and wingers").

(6th Cir. 2004) (affirming denial of certification in medical-monitoring case because "[e]ach individual's claim was ... necessarily proportional to his or her exposure," which would vary from plaintiff to plaintiff based on the facts of his/her case); *Perez v. Metabolife Int'l, Inc.*, 218 F.R.D. 262, 271 (S.D. Fla. 2003) (similar).

Plaintiffs Cannot Establish Significantly Increased Risk On A Classwide Basis. Under a number of states' laws (*see* Ex. 59), each proposed class member would also have to make some showing that exposure to head trauma resulted in a significantly increased risk of injury, another highly individualized requirement. This would require the Court to consider whether each proposed class member's unique injury history puts him at a significant risk of each of the many different neurological injuries alleged. Cantu essentially admitted at his deposition that this would entail an individualized inquiry. (Cantu Dep. 246:12-249:18.)

Although plaintiffs assert that all class members who play in just two NHL games are at an increased risk of NDDCs (Hoshizaki Dep. 12:21-13:6), Cantu testified that: (1) any future study of NHL players would have to demonstrate ***measurable thresholds*** for an increased probability of having NDDCs; and (2) analysis of the relevant thresholds would have to be done ***position-by-position*** (Cantu Dep. 381:12-382:19). This is consistent with Cantu's most recent publication on the long-term consequences of

concussions and subconcussive blows, which found that exposure to total head trauma in football differed significantly based on ***position played and time exposed***.[45]

Further, Cantu admitted that in order to determine "someone's relative risk of CTE," multiple "factors need to be taken into consideration," including concussion history, the circumstances of the concussion(s), "how severe were the concussions," and how long the concussion(s) took to clear. (Cantu Dep. 239:6-240:16.) Cantu also testified that whether a player is at a significant risk of developing CTE would vary based on his medical history and other conditions. According to Cantu, in order to determine whether a significant risk exists, he would want to know "do they have ADD, ADHD? Do they have panic attacks? Do they have depression? Do they have migraine? Do they have seizure disorder? [I]n other words, a whole bunch of comorbid stuff that makes it more likely[.]" (*Id.* 249:1-6; *see also* Hazrati ¶91 ("[E]ach player's risk for developing [neurodegenerative diseases] would depend on a complex interaction of genetic, lifestyle, and environmental factors.").)

In light of this testimony, it would be impossible for plaintiffs to establish a significantly increased risk of CTE or other NDDCs based on common evidence. *See Prempro*, 230 F.R.D. at 570 (denying certification of medical-monitoring class where, *inter alia*, "increased risk" could not be proven on a classwide basis); *Gates*, 655 F.3d at

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[45] Montenigro P.H. et al., *Cumulative Head Impact Exposure Predicts Later-Life Depression, Apathy, Executive Dysfunction, and Cognitive Impairment in Former High School and College Football Players*, J. of Neurotrauma (2016) (Ex. 61).

270 (affirming denial of class certification; "whether class members face a significantly increased risk of developing a serious latent disease ... require[s] considering individual proof of class members' specific characteristics"); *Rink v. Cheminova, Inc.*, 203 F.R.D. 648, 661 (M.D. Fla. 2001) (similar).

Plaintiffs Cannot Establish That All Retired NHL Players Require Medical Monitoring Above and Beyond What Would Normally Be Recommended. Under a number of states' laws, the proposed class members would also have to establish that they require monitoring different from that which would be recommended in the absence of exposure. *See, e.g.*, *Barnes*, 161 F.3d at 146 ("In order to state a claim for medical monitoring, each class member must prove that the monitoring program he requires is 'different from that normally recommended in the absence of exposure.'") (citation omitted). This too would turn on highly individualized evidence. *See St. Jude*, 425 F.3d at 1122 ("[E]ach plaintiff's need (or lack of need) for medical monitoring is highly individualized."); *Rezulin*, 210 F.R.D. at 73 (denying certification of a medical-monitoring class in part because "the evidence shows that many patients formerly on Rezulin already are having blood chemistry tests ... as part of their routine medical care"); *Perez*, 218 F.R.D. at 272 ("[t]his element demands individualized rulings, because many of the individuals would normally be recommended to undergo exactly the same diagnostic screenings and tests based on risk factors other than" the defendant's conduct).

As Dr. Olanow explains, retired players who do not currently allege neurological symptoms cannot establish any need for medical monitoring because there is no evidence that such individuals are "at greater risk to develop a neurodegenerative disease than age-

matched control individuals who never played hockey and who never experienced a head injury." (Olanow Suppl. ¶66.) Nor is there evidence that all proposed class members who claim to be symptomatic need special monitoring above and beyond what they likely are already receiving. After all, plaintiffs' medical-monitoring proposal "does not provide for any symptomatic therapy or other intervention that retired NHL players would not already receive (as medically warranted) in the usual course of treatment from their physicians" for any symptoms they are experiencing. (*Id.* ¶92.) Accordingly, plaintiffs could not satisfy this element on a classwide basis either.[46]

4. Establishing Causation Will Also Require Highly Individualized Inquiries.

a. Warning Causation Will Turn On Individualized Proof.

While state laws differ with respect to negligence, a plaintiff asserting a failure-to-warn claim must generally prove that the failure to warn was the proximate cause of his injury – i.e., had a warning been given, the plaintiff would have heeded it and avoided the injury-causing conduct.[47] Plaintiffs here have not specified what warning they believe

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[46] While Cantu asserted that monitoring is necessary to "allay [the] fears" of retired NHL players about CTE and other alleged long-term risks of head injuries, he admits that such fears have been created by the media, which he says has over-"hype[d]" the alleged risk of these conditions. (Cantu Dep. 476:21-478:4; *see also id.* 352:4-8 (Cantu noting "the fears regarding CTE or even fears regarding concussion," and stating "there's a lot of hysteria that's out there, and it's not accurate").)

[47] *See, e.g.*, *Leoncio v. Louisville Ladder, Inc.*, 601 F. App'x 932, 933 (11th Cir. 2015) ("Under Florida law,…[w]here the person to whom the manufacturer owed a duty to warn…has not read the label, an inadequate warning cannot be the proximate cause of the plaintiff's injuries.") (quotation marks omitted); *Guadalupe v. Drackett Prods. Co.*, 253 A.D.2d 378, 378 (N.Y. App. Div. 1998) (no proof of causation where plaintiff

(cont'd)

the NHL should have provided, but even if they had identified such a warning, each retired NHL player's ability to prove that it would have changed his conduct will depend on a variety of individualized factors.[48]

First, in order to prove warning causation, each player would have to establish that he would not have played professional hockey if he had been warned about the alleged long-term risks of concussions.[49] Plaintiffs cannot possibly make such a showing on a classwide basis. After all, hockey players today continue to compete fiercely for the chance to play in the NHL despite significant publicity – including in feature films and

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"testified that she made no attempt to read the label or to obtain assistance or instruction before using the product, and, indeed, that it was her custom not to do so"); *Yennie v. Dickey Consumer Prods., Inc.*, No. C1-00-89, 2000 WL 1052175, at *1 (Minn. Ct. App. Aug. 1, 2000) ("Under Minnesota law, to prevail on a failure-to-warn claim, a plaintiff must establish that the lack of an adequate warning caused plaintiff's injuries.").

[48] It would be even more difficult for plaintiffs to prove their negligent misrepresentation claims on a classwide basis because proof of reliance on the alleged misrepresentation is generally required and is inherently individualized. *See, e.g., In re Teflon Prods. Liab. Litig.*, 254 F.R.D. 354, 365 (S.D. Iowa 2008) (refusing to certify proposed class; "[b]ecause reliance is a key element of plaintiffs' claim for negligent misrepresentation … an individualized inquiry must be conducted not only to pinpoint the representation(s)" made to each proposed class member "but also to determine the extent to which each plaintiff relied upon the particular representation(s)").

[49] *See, e.g.*, *Yennie*, 2000 WL 1052175, at *1 (affirming grant of summary judgment because the plaintiff presented no evidence that she would have heeded a different warning); *Reis v. Volvo Cars of N. Am., Inc.*, 73 A.D.3d 420, 423 (N.Y. App. Div. 2010) (plaintiff must prove that, had a warning been given, the plaintiff would have read and followed it). Even under the laws of states that recognize a presumption that a warning would be heeded by the plaintiff, the NHL would be entitled to present individualized evidence to rebut that presumption. *See, e.g., Bushong v. Garman Co.*, 843 S.W.2d 807, 811 (Ark. 1992) (the read and heed presumption "may be rebutted by evidence" that a warning would not have been followed).

press coverage of this very litigation – regarding the alleged risks of head hits. Accordingly, the notion that ***no proposed class member*** would have played in the NHL if he received more information about those risks is highly implausible.

The evidence in the record suggests that most retired NHL players would still have joined the League knowing everything they know today. For example, plaintiff Reed Larson testified that he "believe[s] [he] still would have played" in the NHL if the League had provided more information about the possible long-term neurological risks from head hits. (Dep. of Reed Larson 133:15-22 (Ex. 62).) Other former players have similarly stated that they would have played in the NHL even if they had received all of the information currently available about head injuries. *See, e.g.*, Scott Cruickshank, *Despite Concussion After Scary Incident, Westgarth Refuses to Become a Poster Boy for Fighting's Demise*, http://www.calgaryherald.com/sports/despite+concussion+after+scary+incident+westgarth+refuses+become+poster+fighting+demise/9579248/story.html (Kevin Westgarth stating: "[W]e understand the risks. We're doing it ourselves. We're not children. We're not unknowing combatants in this ring. We're completely aware what can happen and what, at some point or another, will happen."); Adam Silvers, *Jeremy Roenick Talks USA Hockey, Lingering Memory Loss From Concussions*, http://www.complex.com/sports/2015/01/jeremy-roenick-interview (Jeremy Roenick stating that despite his concussions, "I wouldn't change a thing, though. I'd go back and play the same way I did before."). By contrast, some players might claim that more or different risk information would have affected their actions. For example, plaintiff Dave

Christian testified that he doesn't "know what decisions [he] would have made" if he had been given more information about the alleged long-term risks of head injuries.[50] (Christian Dep. 289:6-7.)

In short, additional warnings would not have "produce[d] consistent and/or uniform responses and behaviors across the … putative class." (Decl. of Joseph Sala ("Sala") ¶16 (Ex. S).) Accordingly, a jury would need to consider individualized evidence about each plaintiff's willingness to accept risks (including evidence about his other-risk taking behaviors, if any) in assessing the causation element of plaintiffs' claims. (*See id*. ¶40 (noting that "whether a player would alter his behavior" in reaction to a warning "is dependent on that player and his situation").) The need for such individualized evidence further demonstrates why certification is improper.

Second, each proposed class member's ability to prove warning causation will also vary based on his level of knowledge regarding the alleged risk of concussions at the time he was playing.[51] The NHL is not the only source from which players received

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[50] Notably, Christian has never spoken to or warned his nephew, who currently plays in the NHL, about the alleged risks of head hits. (*See* Dep of David Christian ("Christian Dep.") 224:8-225:11 (Ex. 63).)

[51] *See, e.g.*, *Rodriguez v. Sears, Roebuck & Co.*, 22 A.D.3d 823, 824 (N.Y. App. Div. 2005) (there is no duty to warn where "the injured party is already aware of the specific hazard or the danger is readily discernible"); *Auto-Owners Ins. Co. v. Heggie's Full House Pizza, Inc*., No. A03-316, 2003 WL 22293643, at *3 (Minn. Ct. App. Oct. 7, 2003) ("Generally, there is no duty to warn of dangers if the user knows or should know of the potential danger."); *McNearney v. LTF Club Operations Co*., 486 S.W.3d 396, 406 (Mo. Ct. App. 2016) ("There is no duty to warn of a danger when the injured party has actual knowledge of the danger.").

information about the alleged risks of concussions. To the contrary, the proposed class members in this case were represented by an active players' union that had a vested interest in obtaining the most recent information about player health risks, including those related to head injuries, and often discussed the potential long-term effects of head hits with players. [redacted] (*See* p. 23, *supra*.)

Each putative class member's knowledge about the potential long-term risks of brain injuries would also vary based on any questions he asked the NHLPA, team doctors, and his own personal doctors. [redacted]

Players also spoke to their team medical professionals, who provided different patients with different information based on their specific circumstances and the scientific information available at the time. [redacted]

Players also undoubtedly spoke to their own doctors about head injuries that they sustained – and likely received different information about the alleged risks of such injuries. Notably, Cantu testified that he provides different information to different patients about the long-term risks of concussions based on, *inter alia*, the severity of the player's symptoms and the number and timing of any prior concussions. (*See* Cantu Dep. 427:18-429:7.)

Some proposed class members would also have learned about the alleged long-term risks of head injuries from the media. Indeed, by 2010, anyone who played – or even followed – professional hockey would almost certainly have heard about CTE and its possible connection to sport-related head injuries from extensive press coverage of former professional athletes announcing their intentions to donate their brains post-mortem in order to support CTE brain studies. After all, in 2009, former NHL player Keith Primeau publicly announced his intent to donate his brain to researchers at Boston University's CTE Center, an event that was well publicized among NHL players and noted on the League's website. *See* Dan Rosen, *Primeau Opts to Donate Brain for Medical Research*, https://www.nhl.com/news/primeau-opts-to-donate-brain-for-medical-research/c-416495. For all of these reasons, whether a given member of the proposed class was aware of the information plaintiffs claim was withheld requires individualized inquiries.

b. But-For Causation Is An Inherently Individualized Issue.

While causation standards vary among states, most states' laws require plaintiffs to establish that the ***NHL's conduct*** is the "but-for cause" of their alleged injuries.[52]

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[52] *See, e.g.*, *George v. Estate of Baker*, 724 N.W.2d 1, 10-11 (Minn. 2006) (plaintiff cannot establish causation "if the harm would have occurred even without the negligent act"); *Caronia v. Philip Morris USA, Inc.*, No. 06-CV-224 (CBA) (SMG), 2011 U.S. Dist. LEXIS 12610, at *35-37 (E.D.N.Y. Jan. 12, 2011) (plaintiffs must prove that the defendant's "tortious conduct is what caused them … to require medical monitoring"), *aff'd in part*, 715 F.3d 417 (2d Cir. 2013); *In re Estate of Powell*, 12 N.E.3d 14, 22 (Ill. 2014) ("plaintiff must plead sufficient facts to establish that 'but for' the negligence … the plaintiff would not have suffered actual damages").

This inquiry will be highly individualized for two reasons.

First, in states that require plaintiffs seeking medical monitoring to allege physical symptoms, each plaintiff would have to prove that his symptoms were caused by head hits. As Finkel has explained, and as discussed above, "the symptoms alleged by the named plaintiffs and other retired players are nonspecific and ***have many potential causes***," such that "one cannot presume that these symptoms are the direct result of hits to the head." (Finkel Suppl. ¶14(a) (emphasis added).) Instead, identifying the cause of a given player's alleged symptoms would require "a comprehensive evaluation of the patient's unique medical, psychological and social profile." (*Id.* ¶15.)[53]

Second, even in states where subcellular injury suffices, each plaintiff would have to prove that his supposed injuries were caused by head hits sustained ***in the NHL***. Under plaintiffs' theory, even one concussive or subconcussive blow can cause white matter damage – and a resulting risk of long-term neurological damage. (*See* Mem. 26-

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[53] Finkel's examinations of the named plaintiffs highlight why this question is so individualized. [redacted] (Finkel Suppl. ¶19.) [redacted] (*Id.* ¶21.) [redacted] (*Id.* ¶20.) The NHL would be entitled to similar examinations of each proposed class member who claims to be suffering from symptoms related to head hits in order to determine whether those symptoms in fact have other causes.

27.) But most NHL players play competitively, at the collegiate and/or minor league level, before they join the League (and many play professional hockey after they retire from the NHL). Thus, under plaintiffs' own theory, virtually every player would have sustained subcellular injury before joining the NHL. (*See* Olanow Suppl. ¶80 ("if ***any*** concussive or sub-concussive impact could cause white matter damage that … creates a need for monitoring, then most (if not all) NHL hockey players would have reached that threshold long before becoming professional players, whether in youth leagues, high school, college play, in other professional leagues, or from everyday activities that have nothing to do with hockey at all").) Indeed, plaintiffs' own expert concedes as much. (*See* Hoshizaki Dep. 158:19-159:6 (agreeing that the average minor league or college hockey player would have sustained a head impact "sufficient to cause permanent injury to brain tissue" prior to playing in the NHL).)

Each of the named plaintiffs testified that he sustained head hits and checks during play outside of the NHL – including at the collegiate level, in the minors or during Olympic and other non-NHL tournaments. (*See, e.g.*, Christian Dep. 35:22-43:5 (testifying that he sustained head hits while playing in college, World Junior competitions, the 1980 Olympic Games, the ice hockey World Championship tournaments, the Canada Cup tournaments and the International Hockey League).) And several other former players have sustained head injuries entirely unrelated to playing hockey. [redacted]

[redacted] Each of these players would have to present evidence to rule out his non-NHL head impacts as the cause of any increased risk of injury he now purports to have. For this reason, too, plaintiffs cannot satisfy the predominance or cohesiveness requirements for class certification.

B. The NHL's Affirmative Defenses Will Turn On Highly Individualized Evidence That Would Make A Class Trial Unmanageable.

Class certification is also inappropriate because of the need for individualized evidence with respect to potentially applicable affirmative defenses. *See, e.g.*, *Arch v. Am. Tobacco Co.*, 175 F.R.D. 469, 491 (E.D. Pa. 1997) (refusing to certify a class of smokers in part because the defendants' affirmative defenses of contributory negligence, statutes of limitations, assumption of the risk, and consent "raise[d] such individual issues of immense proportions" that class certification "[wa]s obviously inappropriate"); *Prempro*, 230 F.R.D. at 567 ("Assumption of the risk, contributory negligence, comparative negligence, and statutes of limitation all require individual determinations."); *see also Rodney v. Nw. Airlines, Inc.*, 146 F. App'x 783, 786-87 (6th

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54 [redacted] but he now claims the signature was forged (*see* Dep. of Bernie Nicholls 110:9-122:18 (Ex. 71)).

Cir. 2005) (variations related to affirmative defenses pose significant class certification problems, as "a defendant's evidence may be probative of class cohesiveness and may be such as to cause the class to degenerate into a series of individual trials"). Many of the affirmative defenses applicable to plaintiffs' claims are highly player-specific. For example:

Contributory/Comparative Negligence. As set forth in Exhibit 58, most states recognize some form of contributory or comparative negligence, which would limit or bar a proposed class member's ability to recover if the jury determines that he is responsible for some portion of his alleged injuries. Accordingly, the jury would have to evaluate whether each proposed class member played hockey in a manner that was negligent. This would require an individualized inquiry regarding the manner in which he played the sport and whether he took unnecessary risks that led to his purported injury.

Whether a player negligently contributed to his alleged injuries could also turn on whether he accurately disclosed his concussion history in his Player Physical Examination Forms, which several of the named plaintiffs admit they did not do. (*See, e.g.*, Dep. of Gary Leeman ("Leeman Dep.") 378:19-379:1 (Ex. 74) (acknowledging that he incorrectly denied having a concussion history); Dep. of Daniel LaCouture 282:4-15 (Ex. 75) (acknowledging that he misrepresented his concussion history because he "recognized that [he] had a number of concussions by this point" and was "doing anything [he could] to protect [his] job").) A reasonable jury could construe such false statements as evidence of contributory negligence.

Assumption of the Risk. Because many states recognize assumption of the risk, in one form or another (*see* Ex. 58), the jury would also have to consider whether each player knowingly accepted the alleged risks of playing hockey – a full-contact sport – by virtue of his participation in the NHL. Hockey is known to be a physical sport that can result in a wide range of injuries, including concussions. (*See* Sala ¶38 (explaining that "[s]ome players acknowledged that they understood and accepted there was a risk of getting injured and/or receiving concussions").) [redacted] A reasonable jury could find that a given player impliedly assumed the risk of any long-term damage stemming from hockey hits based on his willingness to participate in the sport despite the obvious risk of injuries. *See, e.g.*, *Kingston v. Cardinal O'Hara High Sch.*, 144 A.D.3d 1672, 1673 (N.Y. App. Div. 2016) ("[A] participant assumes the risks that are inherent in the 'sporting or amusement activit[y],' which 'commensurately negates any duty on the part of the defendant to safeguard him or her from the risk.'") (citation omitted); *see also Laughman v. Girtakovskis*, 374 P.3d 504, 508 (Colo. App. 2015) (noting that when participants "voluntarily agree to participate in a sport that is inherently dangerous, ... we assume that each participant knows of the risks associated with such participation"). This is

especially true with respect to proposed class members who continued to play in the NHL after being educated about CTE and other potential long-term effects of concussions [redacted] the NHL/NHLPA Rookie Orientation Program and in individual conversations with medical personnel – and those who continued playing after the filing of this lawsuit resulted in a blitz of newspaper articles and television shows about the alleged risks of playing in the NHL.

A jury could also find that certain players expressly assumed the risk of injury by virtue of signing a waiver acknowledging the risks of NHL play. (*See, e.g.*, Scott Parker 1999 Pre-Participation Medical Evaluation at 11 (Ex. 78) (player certifying that "the team physician has explained to me that playing professional hockey may result in serious physical injury and in the aggravation, deterioration, or reinjury of any preexisting medical condition(s) during and after my employment" and that "I fully understand and assume the possible consequences of playing professional hockey with the medical condition(s) set forth in this questionnaire or discussed with the team physician").) Thus, the jury would have to consider whether each proposed class member gave such a waiver and whether the precise language used therein is sufficient to preclude him from seeking recourse against the NHL under the law applicable to his claims. *See, e.g.*, *Arch*, 175 F.R.D. at 491 ("Assumption of risk is an inherently individual question, turning as it does upon the subjective knowledge and behavior of individual plaintiffs.").

Release of Claims. A jury could also find that certain players have released any potential claims against the NHL. [redacted]

[redacted] And numerous other players have executed releases of claims against the NHL as well. (Daly ¶135.)

Allocation of Fault to Third Parties. Many states recognize allocation of fault to nonparties. (*See* Ex. 58.) Under these states' laws, the jury would have to decide whether to assign fault to the NHLPA based on, *inter alia*, its stance on rules regarding fighting and head hits and its communications to players. These inquiries would be highly individualized, depending on when each class member played in the League, the nature of the hits he sustained, and the NHLPA's role in any applicable rules or communications.

Statute of Limitations. Deciding whether each proposed class member's claim is barred under the applicable statute of limitations will similarly turn on individualized questions, essentially requiring a mini-trial with respect to each proposed class member's case. *See, e.g.*, *Barnes*, 161 F.3d at 149 ("[D]etermining whether each class member's claim is barred by the statute of limitations raises individual issues that prevent class certification."). The statute of limitations applicable to each proposed class member's claims will vary based on the law that governs his claims. (*See* Ex. 58.) In addition, whether each proposed class member's claims are timely under the applicable law will

turn on when each player allegedly sustained the head hit(s) that he claims increased his risk of long-term injury, when he began experiencing the symptoms of the physical injuries of which he now complains and when he became aware of the alleged potential for injury stemming from head hits.

For example, as detailed in the NHL's concurrently filed motion for summary judgment, Leeman's and Nicholls's claims are clearly time-barred under D.C.'s applicable three-year statute of limitations. According to Leeman, the "shot that changed [his] life" – and which forms the basis of his lawsuit – occurred in 1988, decades before he brought suit against the NHL in November 2013. (*Id*. 13-15.) And Nicholls was admittedly aware of all his alleged symptoms – and the purported connection between those symptoms and head hits sustained in NHL play – no later than early 2010, when he filed a workers' compensation lawsuit to recover for his alleged injuries. (*Id.* 16-19.) Other putative class members will present different facts that are relevant to the limitations analysis. (*See* Order at 9-10, ECF 482 (explaining that factual inquiry is required to determine when each plaintiff's cause of action accrued).) For this reason too, individualized issues predominate, precluding certification.

IV. PLAINTIFFS' PROPOSED PERSONAL INJURY ISSUES CLASS (CLASS 2) IS BARRED UNDER EIGHTH CIRCUIT LAW AND IS NOT ASCERTAINABLE.

In addition to their proposed medical-monitoring class, plaintiffs seek certification of a personal injury class ("Class 2") that includes "[a]ll Retired NHL Hockey Players [or representatives thereof] who have been clinically diagnosed with an NDDC[,]" which is defined to include "ALS, Alzheimer's, Parkinson's, CTE, Frontotemporal Dementia,

Lewy Body Dementia, Parkinson's Dementia, and ***any other*** neurodegenerative disease or conditions, as well as ***any*** cognitive, mood, or behavioral conditions where such conditions arose after retirement from the NHL." (Mem. 1 n.2, 29 (emphases added).) Plaintiffs argue that this class can be certified to resolve certain, purportedly common "issues," leaving other individualized questions for later hearings. But Eighth Circuit law bars issues classes of this sort and, in any event, plaintiffs' proposed personal injury class is not ascertainable.

A. The Eighth Circuit Has Rejected Issues Classes Like The One Proposed Here.

The Eighth Circuit has soundly rejected the use of "issue" certification pursuant to Rule 23(c)(4) to evade the predominance and cohesiveness problems that doom the proposed class here. *See, e.g.*, *Ebert*, 823 F.3d at 479; *In re St. Jude Med., Inc.*, 522 F.3d 836, 841 (8th Cir. 2008) (rejecting "issue certification" of medical-monitoring class).

Most recently, in *Ebert*, the Eighth Circuit expressly held that a district court may ***not*** employ a "deliberate limiting of issues" in an attempt to "manufacture[] a case that" satisfies Rule 23. 823 F.3d at 479. There, owners of residential properties in a particular neighborhood in Minneapolis sued General Mills, alleging that it caused a toxic substance to be released into the surrounding environment, which threatened the plaintiffs' health and diminished property values. *Id.* at 476. The district court certified a class with respect to the purportedly common issues of General Mills' liability to owners of the properties in the defined class and the propriety of comprehensive remediation –

with other individualized issues, such as exposure and individual damages, to be determined later. *Id.*

The Eighth Circuit reversed certification on appeal, holding that "narrowing and separating of the issues" in this way "ultimately unravels and undoes any efficiencies gained by the class proceeding because many individual issues ***will*** require trial." *Id.* at 479 (emphasis added). Further, the court noted that "even on the certified issue of liability, there [were] determinations contained within that analysis that are not suitable for class-wide determination." *Id.* For example, in order "[t]o resolve liability there must be a determination as to whether vapor contamination, if any, threatens or exists on ***each individual property*** as a result of General Mills' actions, and, if so, whether that contamination is wholly, or actually, attributable to General Mills in each instance." *Id.* (emphasis added). Thus, "any limitations in the initial action [were], at bottom, artificial or merely preliminary to matters that ***necessarily*** must be adjudicated to resolve the heart of the matter." *Id.* at 479-80; *see also, e.g., St. Jude,* 522 F.3d at 841 (noting that issues certification would be unworkable because "[e]ven courts that have approved 'issue certification' have declined to certify such classes where the predominance of individual issues is such that limited class certification would do little to increase the efficiency of the litigation"); *In re Bisphenol-A (BPA) Polycarbonate Plastic Prods. Liab. Litig.*, MDL No. 1967, 2011 U.S. Dist. LEXIS 150015, at *28-29 (W.D. Mo. Dec. 22, 2011) (rejecting issues trial because "key questions regarding liability" would remain unanswered and pose risks of reexamination in individual trials); *In re Genetically Modified Rice Litig.*, 251 F.R.D. 392, 400 (E.D. Mo. 2008) (Because "a trial limited to common issues would

not resolve any individual plaintiff's claims[,] [t]his approach would do little if anything to increase the efficiency of this litigation."); *In re Vioxx Prods. Liab. Litig.*, 239 F.R.D. 450, 462 (E.D. La. 2006) (rejecting proposal to certify personal injury issues class to determine whether a prescription drug was capable of causing cardiovascular injury because the court would still have to conduct a "highly individualized inquiry of whether [the drug] specifically caused the injury alleged by each plaintiff in light of his or her medical history, family history, other risk factors, and use of the drug").[55]

This binding appellate precedent bars plaintiffs' proposed issues class. Plaintiffs have asked the Court to certify their personal injury class to resolve four purportedly common issues: (1) whether the NHL owed a duty of care under negligence standards; (2) whether the NHL breached that supposed duty, "including by failing to warn" about the alleged risk of "ALS, Alzheimer's, Parkinson's, CTE, frontotemporal Dementia; Lewy Body Dementia, Parkinson's Dementia" or other neurodegenerative diseases; (3) whether head impacts experienced in the NHL substantially contribute to these various

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[55] This Court's ruling in *Cruz v. TMI Hospitality, Inc.*, No. 14-cv-1128 (SRN/FLN), 2015 WL 6671334 (D. Minn. Oct. 30, 2015) (Mem. 67), is not to the contrary. In that putative ***wage-and-hour*** class action, the Court employed Rule 23(c)(4) to bifurcate the questions of liability and damages, reasoning that "liability – not damages – is the focus of the commonality and predominance inquiries" and that liability there would turn on "common evidence of Defendants' hiring practices and job descriptions." 2015 WL 6671334, at *9. Here, by contrast, liability will turn on a number of highly individualized questions that plaintiffs are asking the Court to ignore, contrary to *General Mills*. Plaintiffs' reliance on *In re Target Corp. Customer Data Security Breach Litigation*, 309 F.R.D. 482 (D. Minn. 2015) (Mem. 67-68), which similarly held that individualized ***damages*** questions do "'not ordinarily defeat predominance,'" is misplaced for the same reasons. 309 F.R.D. at 488 (citation omitted).

conditions; and (4) whether retired players are at an increased risk of developing them. (*See* Zimmerman Letter at 4.) But *St. Jude* and *General Mills* make clear that plaintiffs cannot "manufacture" predominance by separating out a few purportedly common issues for class treatment. Further, just as in *General Mills*, an issues class is unworkable because each of the allegedly "common" issues plaintiffs have identified is enmeshed with highly individualized ones.

First, as elaborated above, plaintiffs cannot establish that the NHL "owed a duty of care under negligence standards" (Zimmerman Letter at 4) using common evidence. To the contrary, the existence of a duty on the part of the NHL – be it a duty to warn about each of the various different conditions at issue or a voluntarily assumed duty to protect player safety – will vary from player to player based on when he played in the League, what information was available about the risks of head injuries at that time and what actions the NHL had taken at that point. (*See* pp. 50-54, *supra*.) Plaintiffs allege that the NHL had a duty to warn players that they are at a "permanently increased risk" of developing a variety of different NDDCs. (Mem. 1.) But plaintiffs cannot prove through common evidence that the NHL had reason to know of such a risk with respect to any one of these conditions (much less all of them) over the long course of all the different putative class members' careers.

Further, plaintiffs cannot prove that the NHL voluntarily assumed a duty to every proposed class member by evaluating and encouraging player safety because those efforts changed over time. Most notably, the NHL's development of the Concussion Program and later adoption of a Concussion Protocol are directly relevant to plaintiffs' voluntary-

assumption theory, and those efforts did not begin until 1997. Accordingly, deciding whether the NHL voluntarily assumed a duty by virtue of its player-safety efforts will require the jury to consider when each player played in the League and what actions the NHL had taken at that time.

Second, as detailed above, whether the NHL breached a duty "by failing to warn" about CTE and other NDDCs (Zimmerman Letter at 4) cannot be resolved jointly because the information the NHL has provided to players about the long-term risks of head injuries has changed over time. (*See* pp. 24-25, *supra*.) Thus, there is no specific warning (or absence of a warning) that was uniformly received by all proposed class members with respect to CTE and all the other NDDCs at issue in this litigation. Instead, a jury would have to:

- Review the scientific evidence related to the ***specific neurological condition*** each proposed class member claims to have;
- Determine what information the NHL should have known about the alleged connection between head hits and ***that*** condition ***at the time the proposed class member was playing***; and
- Decide whether the safety information that the NHL was ***providing to players at that time*** was sufficient to warn about that alleged risk.

Such an analysis cannot be performed without separately considering the specific facts of each proposed class member's case. Thus, there is nothing common about the element of "breach" at all.

Third, determining whether "head impacts experienced in NHL-style play substantially contribute to the development of" the various NDDCs alleged by plaintiffs

(Zimmerman Letter at 4) will similarly devolve into highly individualized and fact-intensive inquiries.

For one thing, there is no scientific consensus that a causal relationship exists between head hits and ***any*** of the conditions from which the proposed class members claim to suffer, as detailed above. To the contrary, as Cantu acknowledged, "a cause-and-effect relationship has not yet been demonstrated between CTE and concussions or exposure to contact sports." (Cantu Dep. 335:8-16, 378:18-379:3.) Moreover, the science regarding any link between head hits and the other NDDCs plaintiffs identify in their Complaint is even more tenuous. (Cassidy ¶27 ("[T]here is no reliable or valid scientific evidence that establishes, to a reasonable degree of medical certainty, that concussions can cause long-term neurodegenerative diseases, disorders or conditions."); Yaffe ¶14 (noting that "[t]his is all the more true with respect to subconcussive hits, the study of which is just beginning in earnest in the scientific community"). Plaintiffs' lack of classwide general causation evidence with respect to any of the NDDCs at issue precludes certification of this issue. *Grodzitsky*, 2015 WL 2208184, at *11.

But even if plaintiffs' claims were supported by any valid science, this issue would not be susceptible to resolution on a classwide basis for several reasons.

Plaintiffs seek to certify a class of individuals who allegedly suffer from a wide spectrum of neurological conditions, ranging from ALS to Parkinson's to dementia to "any cognitive, mood, or behavioral condition." Thus, a jury would have to consider

which particular condition each proposed class member claims to have as part of determining this supposedly common issue.[56] In addition, as explained above, Cantu has admitted that any purported relationship between head hits and any of the various alleged long-term injuries plaintiffs allege would depend on the number of hits sustained and their severity. (*See* p. 62, *supra*.) Because each proposed class member has a different history of head injuries (if any), the jury would have to separately determine whether the type or number of hits each retired player sustained is even capable of contributing to one of the NDDCs identified by plaintiffs. Thus, a classwide finding on this issue is not possible either.

Fourth, the related issue of "whether retired players are at an increased risk of developing" each of the various conditions at issue (Zimmerman Letter at 4) also cannot be resolved in the abstract for similar reasons. As already noted, the proposed class members allege different neurological conditions, and whether they are at an increased risk of each of these conditions will necessarily vary. Further, as set forth in detail above, Cantu has admitted that an individual's risk of developing a long-term neurological

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56 [redacted] Thus, in order to determine whether head hits could have caused Zeidel's disease, a jury would first need to determine what that disease actually was.

disease turns on a number of patient-specific "factors," including his pre-existing medical history and the severity and number of head hits he sustained. (Cantu Dep. 239:6-240:16; 249:1-6.) In addition, as McCrory explains, "there has been continued interest by a broad range of researchers in the role of ApoE4 and other genetic risk factors in CTE and other neurodegenerative diseases." (McCrory ¶43.) A jury might reach a different conclusion on the question of increased risk with respect to putative class members who have this genetic marker and those who do not. These and other individualized issues undermine plaintiffs' contention that whether NHL players were at an increased risk of the specific neurological injury from which they now claim to suffer is a common issue that can be resolved in an "issues" trial. Instead, plaintiffs would have to individually prove that each former player has an increased risk based on his particular history. Accordingly, it would not be possible to have a classwide trial of this issue based on common evidence either. *See, e.g., Windham v. Am. Brands, Inc.*, 565 F.2d 59, 66 (4th Cir. 1977) (holding that it would violate the Rules Enabling Act to employ the class device to allow a plaintiff to attempt to prove inherently individualized facts using ostensibly "common" evidence and rejecting issues-class treatment of liability where such individualized issues would preclude manageable resolution of class claims).

In addition, the question whether a given proposed class member is at an increased risk of injury significantly overlaps with issues related to specific causation, which plaintiffs concede will have to be subject to subsequent, individual trials after any purportedly common issues are resolved. For example, if one jury were tasked with deciding whether NHL players had an ***increased risk of*** CTE, and a second jury were

later tasked with deciding whether Zeidel ***suffered from*** CTE, both juries would be considering much of the same scientific evidence. Thus, under plaintiffs' plan, two separate juries would be tasked with addressing overlapping questions, in violation of the Seventh Amendment. *See, e.g.*, *Rhone-Poulenc*, 51 F.3d at 1294, 1303-04 (decertifying proposed issues class because "[t]he first jury ... will determine merely whether one or more of the defendants was negligent," which "overlaps" with the issues to be resolved "in individual follow-on litigation," creating a "looming infringement of Seventh Amendment rights"); *In re ConAgra Peanut Butter Prods. Liab. Litig.*, 251 F.R.D. 689, 698-99 (N.D. Ga. 2008) (rejecting issues class with respect to the "knowledge, conduct, and duty" of the manufacturer of allegedly tainted peanut butter because "the risk that a second jury would have to reconsider the [common] liability issues decided by the first jury is too substantial") (citation omitted).

For all of these reasons, plaintiffs' issues class proposal should be rejected.

B. <u>There Is No Objective Way To Determine Who Is A Member Of The Proposed Personal Injury Class.</u>

Plaintiffs' proposed "Class 2" also fails the "ascertainability" requirement because there is no administratively feasible way to determine who falls within the proposed class definition.

The Eighth Circuit recently noted that "[m]ost of the other circuit courts of appeals have 'recognized that Rule 23 contains an implicit threshold requirement that the members of a proposed class be "readily identifiable."'" *Sandusky Wellness Ctr., LLC v. Medtox Sci., Inc.*, 821 F.3d 992, 995 (8th Cir. 2016) (citation omitted). As it explained,

the "circuits diverge on the meaning of ascertainability," with the Third Circuit and others applying a "heightened" ascertainability requirement that requires plaintiffs to prove that ascertaining class membership would be administratively feasible – and the Seventh Circuit finding that ascertainability is just one factor in the certification analysis. The Eighth Circuit declined to "outline[] [the] requirement of ascertainability," but held that "[i]t is ***elementary that in order to maintain a class action, the class sought to be represented must be adequately defined and clearly ascertainable***." *Id.* at 996 (emphasis added) (citation omitted); *see also Karhu v. Vital Pharm., Inc.*, 621 F. App'x 945, 946-47 (11th Cir. 2015) (a proposed "class is not ascertainable unless the class definition contains objective criteria that allow for class members to be identified in an administratively feasible way"). Further, the Eighth Circuit reiterated its previous holding that certification is inappropriate where it "'would be impossible to determine [class membership] because of the vagueness of [the class] description.'" 821 F.3d at 996 (citation omitted).[57]

Plaintiffs' proposed Class 2 fails these requirements because there is no way to objectively determine whom it encompasses.

Class 2 includes retired NHL players who have been clinically diagnosed with an "NDDC," a term that is nebulously defined to include ***any*** cognitive, mood, or behavioral

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[57] In *Sandusky*, the court found that a proposed class composed of persons who, *inter alia*, "were sent telephone facsimile messages regarding lead testing services" satisfied these requirements because "the numbers that received each fax are objective criteria that make the recipient clearly ascertainable." *Id.* at 996-97.

conditions. (Mem. 1 n.2.) Having examined four of the named plaintiffs in this case, Dr. Olanow concluded that there is "no medical or scientific basis upon which to differentiate the neurological conditions of" Leeman, who claims to have been diagnosed with a neurological injury and asserts personal injury claims, from "the named plaintiffs proposed to represent subclass 1," who do not claim to have a present injury. (Olanow Suppl. ¶35.) According to Olanow, "all four [plaintiffs] had basically normal neurological examinations" and there was little to nothing to separate them "from millions of Americans in this age group who do not suffer from clinically significant [NDDCs]." (*Id.* ¶¶36-37.) Further, Olanow explained that Cantu "has not described any clinically significant findings that would allow differentiation among the plaintiffs."[redacted] (*Id.* ¶39.) While Leeman complained of various non-specific symptoms, so do the other named plaintiffs. (*Id.* ¶21.) In fact, LaCouture reported more symptoms of a greater severity on Cantu's symptom checklist than Leeman did. (*Id.* ¶94 n.92.) Moreover, Leeman's claims of "balance problems" (SAC ¶44) and Cantu's finding of balance issues on his neurological examination of Leeman (Cantu Leeman IME at 5) are belied by

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[redacted]

Leeman's participation in a December 2016 NHL alumni game, a video of which shows him "skating rapidly … exhibiting impressive coordination and balance," and rising immediately after being tripped "without any evidence of imbalance or neurological impairment." (Olanow Suppl. ¶46.) Thus, it appears completely arbitrary that Leeman and the other living named plaintiffs were assigned to different proposed classes.

Determining class membership will be further complicated because plaintiffs' definition only includes retired players whose diagnosed "condition[s]" "arose after retirement from the NHL." (*Id*. ¶34.) Under this definition, Leeman is not even a member of the putative class he seeks to represent. After all, Leeman has testified that his alleged symptoms began when he was hit in the head by a slapshot in 1988, almost a decade before he retired from the NHL. (*See* Leeman Dep. 92:14-93:17, 247:12-16.) Thus, his alleged condition did not "ar[i]se" after his retirement. Similar inquiries would be required with respect to each proposed class member.

Plaintiffs argue that their proposed class definition is ascertainable because it turns on whether a proposed class member has been diagnosed with a neurodegenerative disease or condition, which plaintiffs claim is an objective inquiry. (Mem. 41.) But plaintiffs rely primarily on the *NFL* court's settlement ruling for this proposition – and that decision does not even address the ascertainability requirement. *See In re NFL Players Concussion Injury Litig.*, 307 F.R.D. 351, 379 (E.D. Pa. 2015). Further, the *NFL* opinion actually undermines plaintiffs' ascertainability argument because the court there

expressly noted that "mood and behavioral" conditions, which are included in the class definition here, are not "objectively measureable symptoms." *Id.* at 397.[59]

For all of these reasons, plaintiffs' proposed Class 2 fails on ascertainability grounds as well.

V. THE PROPOSED CLASS REPRESENTATIVES CANNOT ADEQUATELY REPRESENT ALL RETIRED NHL PLAYERS.

Plaintiffs also fail Rule 23(a)(4)'s adequacy requirement because they seek to certify a medical-monitoring class consisting of all former NHL players, but are asserting personal injury liability on behalf of only ***some*** of those individuals. If putative members of the medical-monitoring class sought to bring personal injury cases in the future, they could well find themselves precluded from suing. This potentially preclusive effect creates a significant conflict between the plaintiffs and the proposed class members that makes them inadequate class representatives. *See, e.g.*, *Thompson*, 189 F.R.D. at 550-51 (denying class certification of medical-monitoring class for lack of adequacy; because "[a] subsequent court may very well find that individual injury and damage claims should

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[59] Plaintiffs' other authorities are equally off-point. In *Diet Drugs*, 1999 WL 673066, at *13 (Mem. 41), membership in the proposed class did not turn on proof of diagnosis and the court in no way indicated that such a class would be ascertainable. Indeed, the proposed class there involved medical-monitoring claims alleged by individuals who did ***not*** contend that they had personal injuries. And in *M.G. v. New York City Department of Education*, 162 F. Supp. 3d 216 (S.D.N.Y. 2016), the court noted that "precise ascertainability [was] not required" because the plaintiffs there – unlike the personal injury plaintiffs here – sought "injunctive, not monetary, relief" and it was "not necessary to identify [class members] to administer [that] relief." *Id.* at 238, 241.

have been litigated in this lawsuit," certification may "jeopardize the class members' rights to bring such claims in a subsequent case"); *Teflon*, 254 F.R.D. at 367 (refusing to certify class because plaintiffs "risk[ed] a future waiver" of absent class members' claims for personal injury and medical monitoring) (citing *Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*, 533 F.3d 634, 641 (8th Cir. 2008)); *In re Fosamax Prods. Liab. Litig.*, 248 F.R.D. 389, 401 (S.D.N.Y. 2008) (adequacy not met where plaintiffs sought "monetary damages for themselves but only medical monitoring for the class," which led to the possibility of "substantial prejudice to other class members" because "[r]es judicata may preclude class members from later litigating personal injury claims"); *Perez*, 218 F.R.D. at 272 (denying certification on adequacy grounds where "the preclusive effect of providing medical monitoring to this class may bar unnamed class members from bringing claims for injuries actually suffered," thereby "creat[ing] a conflict between the named Plaintiffs and any unnamed members who had sustained an actual injury"). Such intractable conflicts cannot be cured without a "structural assurance of fair and adequate representation" – i.e., the appointment of independent counsel for each subclass to ensure that the antagonistic interests are adequately represented in each subclass. *E.g.*, *In re Payment Card Interchange Fee & Merchant Disc. Antitrust Litig.*, 827 F.3d 223, 233-36 (2d Cir. 2016) (quoting *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 627 (1997)) (concluding that the interests of a subclass assigned only prospective injunctive relief under (b)(2) were sufficiently antagonistic to a class receiving retrospective monetary relief under (b)(3) to require independent representation), *cert. denied*, No. 16-710, 2017 WL 1115037 (Mar. 27, 2017).

VI. A CLASS ACTION IS NOT THE SUPERIOR MECHANISM FOR RESOLVING PLAINTIFFS' CLAIMS.

Finally, plaintiffs' class proposal fails Rule 23(b)(3)'s superiority requirement because a class action is not the superior mechanism for resolving plaintiffs' claims.

First, plaintiffs' proposed medical-monitoring class is improper because "[c]ourts generally lack 'the technical expertise necessary to effectively administer a program heavily dependent on scientific disciplines such as medicine.'" *Caronia*, 5 N.E.3d at 18 (citation omitted); *see also Prempro*, 230 F.R.D. at 570-71 (rejecting proposed medical-monitoring class; "this is not the case for a court to take [the] lead, based upon the singular opinion of Plaintiffs' experts"); *Baycol*, 218 F.R.D. at 207, 211-12 (declining to certify medical-monitoring class because, *inter alia*, "there is a lack of medical or scientific evidence, with the exception of Plaintiffs' expert, which suggests or recommends that individuals who took Baycol, and have remained asymptomatic, should have their creatinine levels and blood pressure tested"); *Propulsid*, 208 F.R.D. at 147 (rejecting medical-monitoring class; "The courtroom is not the place for scientific guesswork, even of the inspired sort. Law lags science, it does not lead it.") (citation omitted).

The medical-monitoring program proposed by plaintiffs has "never been described by any medical clinical practice guidelines to date," including those by the U.S. Preventive Services Task Force, the NIH's Office of Disease Prevention or the International Consensus Conferences on Concussion in Sport. (Finkel Suppl. ¶¶24-27, 57.) Instead, plaintiffs are asking the Court to endorse a "new clinical practice guideline

that currently is not supported by scientific evidence." (*Id.* ¶28; *see also* Brenner ¶63 (the relevant research has not "reached a point of maturity sufficient to support the development of clear CPGs to guide treatment or medical advice to patients with a history of participating in contact sports").) Moreover, the proposed monitoring program "will not help, and ***may harm***, individuals whose symptoms are the result of causes other than hits to the head." (Finkel Suppl. ¶14(c) (emphasis added); Olanow Suppl. ¶96.) For this reason too, certification should be denied.[60]

Second, superiority is also lacking because plaintiffs are asking the Court – in the guise of a request for medical-monitoring relief – to make the NHL pay for an epidemiological study that plaintiffs hope to use in pursuit of personal injury cases. As Cantu has admitted, a causal link between head trauma and CTE "remains to be shown," and there is no "solid scientific basis" to predict the risk to any hockey player. (Cantu Dep. 246:12-252:7, 385:14-18.) The Court should not interfere in ongoing scientific research at the behest of private, interested parties, and the NHL should not be judicially forced to fund plaintiffs' efforts to develop the scientific evidence they are lacking to prove their claims. *See Propulsid*, 208 F.R.D. at 147 (rejecting request for funding of

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[60] Plaintiffs' medical-monitoring request also fails to satisfy the superiority requirement because many putative class members will refuse to participate in it. Leeman refused to undergo an MRI for purposes of this litigation, because his counsel said he had "claustrophobia" (*see* Olanow Suppl. ¶95), and two former named plaintiffs refused to undergo IMEs altogether (July 12, 2016 Ltr. from S. Davidson to Hon. S. Nelson at 1 (Ex. 85); Joint Stip. to Dismiss Without Prejudice, ECF 27, *Ludzik v. NHL*, No. 0:15-cv-03110-SRN-JSM (D. Minn. filed May 17, 2016)).

clinical study where plaintiffs lacked scientific evidence to support their theory). This is all the more true because the studies plaintiffs propose would rely upon voluntary participation of retired NHL players, likely resulting in ascertainment bias – i.e., that "players who perceive themselves as having problems would be more likely to participate than players who believe that they are healthy." (Randolph ¶27.) In addition, the studies do not contemplate any control data – i.e., information "from a sample of men demographically matched to NHL retirees with no history of extensive involvement in contact sports." (*Id.*) Thus, the validity of the study results would be dubious at best. (*See* Cassidy ¶¶119-20.)

Third, the superiority requirement is not satisfied because plaintiffs are not asserting negative-value claims. "The most compelling rationale for finding superiority in a class action is whether the action is a negative value suit," *Baycol*, 218 F.R.D. at 210 – i.e., "where the costs of individually litigating the action exceeds the potential recovery," *Benner v. Becton Dickinson & Co.*, 214 F.R.D. 157, 173 (S.D.N.Y. 2003) "[P]ersonal injury claims, however, do not present such a suit" because they can result in significant recoveries when litigated individually. *Baycol*, 218 F.R.D. at 210; *see also Benner*, 214 F.R.D. at 173; *Arch*, 175 F.R.D. at 496 (superiority lacking with respect to medical-monitoring and personal injury claims because "individual lawsuits by the putative class members would [not] be negative value suits"). The same is true here, as evidenced by the fact that more than 100 retired NHL players have filed individual lawsuits against the NHL based on essentially the same allegations advanced by the named plaintiffs here. *See Arch*, 175 F.R.D. at 496 n.28. Moreover, according to Cantu,

plaintiffs' medical-monitoring proposal would cost approximately $10,250 per individual for an initial medical examination, plus an additional $3,500 per person every five years for the remainder of each proposed class member's life. (*See* Cantu ¶¶136-44.) Thus, these claims have more than enough value to proceed individually as well.

In short, even if it were proper to bend class certification rules for negative-value claims (and it is not), this is by no means such a case.

CONCLUSION

For the foregoing reasons, the Court should deny plaintiffs' motion for class certification.

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